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NATIONAL ASSOCIATION
FOR
MENTAL HEALTH

Report of the Proceedings
of a
CONFERENCE
on
MENTAL HEALTH

held at Seymour Hall, London, W.1

15th—16th JANUARY, 1948

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CONFERENCE on MENTAL HEALTH

15th and 16th January, 1948
held at Seymour Hall, London, W.1

Programme

THURSDAY, JANUARY 15th

MORNING SESSION, 10.30 TO 1.0

Chairman: **The Rt. Hon. R. A. Butler, M.P.**

Opening Address by **L. John Edwards, Esq., O.B.E., M.P.** (Parliamentary Secretary, Ministry of Health)

Subject:

RE-ADAPTATION TO LIFE AND WORK OF PERSONS WHO HAVE SUFFERED FROM NERVOUS OR MENTAL DISORDER

Speakers:

G. R. Hargreaves, O.B.E., M.R.C.S., L.R.C.P. (Principal Medical Officer, Lever Bros. & Unilever Ltd.)

Donald Stewart, M.D., F.R.C.P. (Medical Adviser, Austin Motor Company, Babcock & Wilcox Ltd. and James Booth & Company; Member, Industrial Health Research Board).

THURSDAY, JANUARY 15th

AFTERNOON SESSION 2.30 TO 5.0

Chairman: **C. P. Hill, Esq.** (Assistant Secretary, Children's Department, The Home Office).

Subjects:

(a) METHODS OF HANDLING DIFFICULT CHILDREN IN PRIMARY AND POST-PRIMARY SCHOOLS AS REQUIRED UNDER THE EDUCATION ACT, 1944.

(b) THE SELECTION AND TRAINING OF STAFFS FOR BOARDING HOMES FOR DIFFICULT CHILDREN.

Speakers:

E. M. Bartlett, B.A., Ph.D. (Psychologist, Essex Education Committee).

Clare Britton (Tutor, Child Care Course, London School of Economics; late Psychiatric Social Worker, Oxfordshire County Hostels Scheme).

FRIDAY, JANUARY 16th

MORNING SESSION 10.30 TO 1.0

Chairman: **W. Rees Thomas, K.H.P., M.D., F.R.C.P., D.P.M.** (Senior Commissioner, Board of Control).

Subject:

THE RESPONSIBILITIES OF LOCAL AUTHORITIES IN RELATION TO MENTAL HEALTH AND THE NATIONAL HEALTH SERVICE ACT, 1946.

Speakers:

Kenneth Soddy, M.D., D.P.M. (Medical Director, National Association for Mental Health).

Doris M. Odlum, M.A., M.R.C.S., L.R.C.P., D.P.M. (Vice-President, National Association for Mental Health).

FRIDAY, JANUARY 16th

AFTERNOON SESSION 2.30 TO 5.0

Chairman: **The Earl of Feversham, D.S.O., D.L., J.P.**

Subject:

EDUCATION FOR MENTAL HEALTH AS A NATIONAL AND INTERNATIONAL RESPONSIBILITY.

Speakers:

Brig. A. Torrie, M.A., M.B., Ch.B., D.P.M. (Director of Army Psychiatry).

Sibyl Clement Brown, M.A. (Programme Secretary, International Congress on Mental Health; late Tutor, Mental Health Course, London School of Economics).

THURSDAY, JANUARY 15th

MORNING SESSION

Chairman:

The Rt. Hon. R. A. Butler, P.C., M.P.

(*President, The National Association for Mental Health*)

The Chairman: Ladies and Gentlemen: We have a very full agenda this morning, and prior to the very pleasant duty I have of introducing to you the Parliamentary Secretary to the Ministry of Health, Mr. L. John Edwards, and other speakers who are to follow, I hope you will bear with me for a few minutes while I make one or two observations about the work of the Association.

I would like to begin by saying a few words about the year's work. The year, I think, has been a satisfactory one and we are getting on well. We are anxious not to become more and more dependent on official sources for support for the continuance of our activities, and we are urgently in need of funds in order to carry on and to develop all aspects of our vital work—educational activities, social services for children and adults suffering from nervous disorders and mental defects, provision of homes and hostels, and propaganda in relation to the prevention of mental ill-health. These are typical examples of the work for which we want to enlist general support.

We hope, therefore, that the general public will take the simplest step of all, and that is to join the Association as members, because in that way very practical help can be given. The present membership of the Association is far too small and it is our earnest wish very considerably to enlarge it and to use all our influence to that end. We have enormous opportunities, arising out of the Education Act of 1944 and the National Health Service Act of 1946, for the development of a truly effective nation-wide service, and in this task our Association will be required to play a leading part. I therefore make a confident appeal to you, who are those who take the chief interest in our work, and to the public generally, to come along and join up and help this great crusade.

During the past year it was possible to put into effect the plan for naming the Association's premises after the late Sir Maurice Craig, C.B.E., M.D., F.R.C.P., who was a pioneer in the treatment of mental disorders, and, with Dr. Helen Boyle, a founder of the National Council for Mental Hygiene —one of the constituent bodies responsible for setting up this new amalgamated Association and which did so much for our work.

Funds were collected some years ago by friends of the late Sir Maurice Craig, on behalf of the National Council for Mental Hygiene, for the purpose of founding a " Maurice Craig House " which would be the centre for national voluntary organisations in the mental health field. These funds have now been handed over to the National Association for Mental Health for the development of its activities, and you will be glad to hear that a plaque has been erected naming the Association's premises " Maurice Craig House ".

It only remains for me to mention one other very important matter, and that is the International Congress on Mental Health, organised by the National Association for Mental Health, which is to be held at the Central Hall, Westminster, from 11th—21st August this year. This will be the third World Congress to take place since the founding of the Mental Hygiene Movement; the first took place in Washington in 1930, and the second in Paris in 1937. The Congress will include three separate international Conferences—on Child Psychiatry, on Medical Psychotherapy and on Mental Hygiene—and I think it is most important that we should take the opportunity of this great gathering here to do all we can to pledge ourselves to make it a great success. We have had much official support for the Congress, and I should like to convey through you, Mr. Edwards, on the occasion of your visit here this morning, our thanks to the Government for their support. The Prime Minister himself has agreed to be one of the Patrons, as also Mr. Anthony Eden, and we are very honoured in having the gracious patronage of H.R.H. The Duchess of Kent. Contact has already been established with some forty-four countries, and large delegations are expected from abroad.

We shall have to keep up the reputation London has gained as the most hospitable capital city in the world. I trust that this appeal which I am making to you, to use all your contacts and all your skill to ensure the success of the Congress, will not fall on deaf ears.

I now have the greatest pleasure in introducing to you the Parliamentary Secretary to the Ministry of Health, Mr. L. John Edwards, O.B.E., M.P., who will give us a short and informal address and who hopes to stay with us for part of the morning. We are extremely glad to have him with us to-day; we know of his intense interest in Mental Health, of the great services that he renders to the Ministry of Health, and of the sincere application which he brings to the performance of his duty.

INAUGURAL ADDRESS

L. John Ewards, Esq., O.B.E., M.P.

(*Parliamentary Secretary, Ministry of Health*)

Mr. President, Ladies and Gentlemen: I am very glad indeed to be here this morning, if only, as it were, to assure you of the interest which the Ministry of Health takes in the work of your Association and in the proceedings of this Conference.

I have with me this morning the Chairman of the Board of Control who represents the official side of the Ministry, and if there were any doubt about our approval of this Conference I think it would be settled by a reference to the notes on delegates' expenses on the back page of your Agenda.

The National Association for Mental Health is, I think, quite indispensable in the field of work concerning mental health, and I would echo what your President said just now, but putting it differently, and say it is a Voluntary Association, it ought to remain a Voluntary Association, but it can only continue to flourish to the extent to which men and women throughout the country take interest in it and support it.

I wondered what I should say to you this morning. As a layman I thought I had nothing to contribute on the more technical matters which you would be discussing. It is true that some twenty years ago, I did begin to read psychology at the University, and even began what was intended to be a research masterpiece on the subject of dreams. But that was a long time ago. I could, perhaps, have dealt with the Mental Health Services in relation to the National Health Services; but it seemed to me that that would take too long—and in any event you are to devote a whole morning session to one part of that subject. I concluded, therefore, that the best thing that I could do would be to talk in general terms, and what I have to say to you really consists of the things that came into my head as I browsed over the Programme—a sort of meditation, if you like, on reading the Conference Programme.

I want to begin by reminding you of words which no doubt you know very well, words that come from the reflections of John Donne when he was listening to the tolling of the passing bell. He wrote: "No man is an Iland, intire of it selfe. . . ." and then, later: "Any man's death diminishes me, because I am involved in Mankinde; And therefore never send to know for whom the bell tolls; It tolls for thee."

It is those words " I am involved in Mankinde " which I think are worth while emphasising. However technical your discussions may be in these two days, I am sure you will agree that it is desirable to keep in mind the individuals whom the Mental Health Service exists to serve; the patients, the mentally deficient, the difficult child, the neurotic man or woman who comes for rehabilitation. All these people are part of us. To be involved in mankind is to be involved in them. I believe that it is always a good thing for all of us—be we doctors, nurses, politicians, or Local Authority representatives—in all our work, to bear in mind some individual persons whom we are seeking to serve.

These considerations are not merely national, our involvement is world wide. I hope therefore with all my heart that this Conference is going to be a good preparation for the great International Congress which is to take place later in the year and in the organisation of which the Association will have the fullest support from the Ministry of Health.

One thing that pleases me is that this Conference consists very largely, I am told, of laymen and laywomen as well as professionals. I hope I shall not be thought disrespectful if I say that I am very glad about that because I think it will keep the professionals in their place. I think that one of the difficulties of those who practise in the field of psychology or psychological medicine has always been that of communicating with one another, and the presence of intelligent lay folk always means that the professionals who talk have got to try to be as precise as they can and to put what they have to say in simple and everyday terms. I remember some words of a psychologist written as far back as 1924 when in a flippant mood he wrote: " We shall have to give over the fun of arguing words and begin to face facts. Our intellectual joust is over. It is time to plant some beans." Now, it is this business of planting beans which I consider important. That is why I congratulate those who organised the Conference on the practical bias which has been shown in the programme. The matters to be discussed are, for the most part, essentially immediate and practical, upon which those who are trained in the sciences concerned may cast some light, but in the working out of which, all of us are involved.

First in the series of topics which you will consider is the question of rehabilitation. Certainly, as one of the psychologists has put it, " how we may avoid disaster and how we may regain the right track," is of the first importance. Some twenty years ago, when I was a student, I had to study a book which no doubt is regarded nowadays as out of date, a book called "The Abilities of Man", by Professor Spearman. I have forgotten very much of that book—the arguments to prove what I think was called the universality of "g", the enormous statistical tables of tetrad differences—but there was one paragraph which impressed me then and has often been in my mind since: Professor Spearman, at the end of one chapter, talks of looking, as one did in those dreadful days, at a procession of unemployed and hearing the common remark that they were mostly the unemployable, and then he goes on to say: "That they are so, actually, one can hardly help concurring. But need they be so necessarily? Remember that every one of these, too, is a genius at something—if only we could discover what." So, in the work that we do nowadays in rehabilitation our emphasis is always on equipping people to fulfil the highest function that they can, not just any old function, but really trying to find what people are good at and then putting them in the right place.

Then, too, you are to discuss the problem of difficult children. I have two difficult children, but they always insist that the difficulties arise not from anything that is wrong in them but from the enormous amount that is wrong in me. And perhaps they may be right. Certainly in your discussions on this subject you will be well advised to take equal care to consider the second part of the subject—the selection and training of those who are to take charge of the children in the Boarding Schools, because these staffs who are the mothers and fathers for the time being of the children there, will have the greatest influence over the children. The difficulties which arise are always and at all times, as much the difficulty of the adult as the difficulty of the child.

Then later in your Conference I am very glad to see that you are going to give attention to the responsibilities of Local Authorities in relation to mental health and the National Health Service Act. Many matters of immediate and practical importance arise in this sphere of work, and, although the Local Authorities will no longer be responsible for the provision of hospital accommodation, they will have great responsibilities and great opportunities in the social care of persons who may need treatment for mental or nervous disabilities. It will, I think, depend largely upon the efficiency and vigilance of the Local Authorities' service whether the incipient case needing treatment is brought within the reach of the necessary facilities for treatment at that early stage when preventive treatment can be of the greatest value. At the other end of the scale, the restoration to normal life of a patient discharged from hospital may depend to a very great extent upon the After-Care organisation of the Local Authority. I feel confident that the exchange of views on these functions of Local Authorities will be helpful when the new Act comes into operation next July. But let there be no misunderstanding about this. No miracle happens on the 5th of July next. Make no mistake about it, however well we may progress as the years go on, in the provision of new buildings and so on, the service will always ultimately depend on the quality of the people in it, whether they be doctors, nurses, clerks, or the locally elected and co-opted representatives who serve on the various committees.

I would conclude what I have have to say to you with a few general remarks on the setting in which this Conference is taking place. It is a commonplace to say that technical progress has been prodigious and that our capacity to live together and to work together has diminished. We have learned to adapt and control our physical environment, while our feelings and behaviour seem to be as wayward as ever, or perhaps more wayward than ever. We have seen and known in our own recent times that abominable things can be done in the name of a false faith. It is for us, in our day and generation, to show by what we say and perhaps even more by what we do, what a true faith means. Psychology is, of course, not a faith. It is a science, an applied science, perhaps in some respects a craft; but those who are trained in it and those who work in the field of mental health have a contribution which they and they alone can make. The sciences involved in mental health do not tell us where to go; I think they presuppose where we have to go but I believe they can help all of us who are trying to go along the authentic democratic road. As I look at it, I think one can say—and I hope you will agree—that we want people to be free, not by being independent but by being conscious of mutual dependence, of being members one of another. We want people to be creative, not in the sense of doing what they like but of liking what they do. We want people to have increasing power over things, always constrained by essential respect for persons.

I would clinch the point by a reference to a letter from an American diplomat which I was reading in a book only this week-end, a letter written in 1942, in which he said: " Harry Hopkins, after his first visit to England, brought back one particularly vivid discovery—that the strength of a nation depended on the strength of its organisation in depth." And later in the letter he said: " The principle of organisation in depth is as valid for the needs of peace as for war. It can be used not only on our external but on our internal frontiers to conquer the devils of waste and indifference as well as the Germans."

It is these considerations which lead me to conclude by reaffirming that the work of the Association is really worth while. It is helping to carry on the job of "organisation in depth," helping to do something on the human level which may, to some extent, act as an antidote to some of the bad things which we all do so frequently on the purely technical level. Because I believe this I shall always be happy to help the Association in any way that I can.

Mr. President, I wish you and the Conference every success. I look forward to the International Congress next summer, and I hope the Association will make good progress in its splendid work.

RE-ADAPTATION TO LIFE AND WORK OF PERSONS WHO HAVE SUFFERED FROM NERVOUS OR MENTAL DISORDER

G. R. Hargreaves, O.B.E., M.R.C.S., L.R.C.P.
(Principal Medical Officer, Lever Bros. and Unilever Ltd.)

What is the size of the problem which we are here to discuss to-day: the problem of readaptation to normal life of individuals who have suffered from nervous or mental illness? Mental illness, as we know, produces serious disorders of behaviour and thinking and must therefore often be treated in mental hospitals. The existence of these hospitals, and the tendency on the part of the community in the past to attach a stigma to mental illness has probably given most people a false idea of the frequency of psychological disorders of this type. In fact, they are not common, nothing like as common as the neuroses, which are colloquially referred to as " nervous diseases ".

There have been various estimates made as to the proportion of all illness which results from neurosis; these estimates range all the way from 10% to 60%, but none of them can be very helpful to us in defining our problem unless we first of all state what we mean by " the proportion of all illness ". I think that the best way to try to gauge the size of the problem of neurosis is to ascertain what proportion of incapacity results from this cause—incapacity, for instance, in the sense of absence from work.

Using sickness absence in industry as the index of incapacity, Dr. Russell Fraser, in a very extensive enquiry which he conducted for the Medical Research Council, has been able to show that men in industry are absent from work on account of neurosis to the extent of 1% of their time. This is between one-third and one-quarter of all time lost through sickness—and women lose over twice as much. With a five-day week, therefore, it means that neurosis costs the community 2½ days' work per man per year, and double that for women.

That, then, is an estimate of the total incapacity that arises from this source; and it may surprise you to learn that this is probably greater than the incapacity caused by colds and influenza which are always assumed to be the highest single cause of incapacity. How common are neuroses? Does the community lose this 1% to 2% of working time through a few very long illnesses, or a lot of very short ones? Here again, Dr. Russell Fraser's survey can provide us with an estimate. About 8% of the community had suffered from disabling and definite neurosis during the course of the six months prior to the survey, and a further 16% had suffered from some minor form.

That is the size of the problem. What are we doing about it? What are we doing to help such people resettle themselves in productive work in the community? The first step to resettlement is, of course, effective treatment—not at the stage when the individual is incapacitated for work but before that happens, when he or she is first beginning to flag. We need, therefore, adequate facilities for out-patient consultation and psychological treatment. Have we got them? Not in numbers and quality that are anything like adequate; and such clinics could not be set up without adequate training facilities for psychiatrists and for the other members of the mental health team—psychologists and psychiatric social workers.

But even if we have adequate provision of facilities for diagnosis and for out-patient facilities for psychological treatment, there still remains a need for in-patient hospital facilities for cases of neuroses. Many of you probably know that whether neurosis should be treated in special centres or in general hospitals is still a hotly debated point; but at present the facilities for such treatment, again, are quite inadequate. The in-patient treatment of neurosis in most general hospitals consists of neglect and a bottle of medicine. At the other end of the scale, the mental hospitals were designed and built for the custodial care of psychotic mental illness and, with few exceptions, cannot provide adequate in-patient treatment for cases of neurosis. We are left with the very small group of hospitals which were founded for the in-patient treatment of neuroses and early mental disorder such as the Cassel Hospital and the Maudsley Hospital.

The war provoked considerable development in this field; some of the E.M.S. and Service Neurosis Centres, although pressed for time and limited in the stay they could permit their patients, provided facilities for in-patient treatment of neurosis of a quality and on a scale which had never existed in this country before. As the war ended, they were mostly closed, but they have left some trace. The Roffey Park Rehabilitation Centre, which treats cases of neurosis from Industry, is a pioneer in its own particular field which owes something to these war-time developments, as does the Princess Elizabeth's Industrial Rehabilitation Centre of the London County Council. We need far more in-patient neurosis centres of this type. I emphasise this matter of adequate treatment facilities because every family doctor and

Industrial Medical Officer knows of individuals who could be kept going if they could get out-patient treatment before they are finally in a state of breakdown; and every doctor knows that once an individual is incapacitated with neurosis, it is exceedingly difficult to obtain for him adequate in-patient treatment.

So much for our need for treatment facilities. When the patient has received treatment, he will need help in getting back into his stride again—rehabilitation, as it is fashionable to call it. In the last few years a fair amount has been done, and much has been said and written in this field, but in some ways I feel that there is a false perspective in the usual presentation of this problem. Most discussion of rehabilitation is based on the assumption that the basic problem involved is that of getting an orthopaedic case back to work in a light engineering factory. Now you will see from the figures I quoted at the beginning of this talk, that neurotic incapacity is responsible for much more loss of time than are fractures, or eye injuries, or amputations or similar surgical disabilities. I feel, therefore, that the ingenious adaptation of the controls of light engineering machinery, to enable it to be used by individuals with surgical disabilities, is not the main need in rehabilitation. Every Works Manager will tell you that he has no problem in the rehabilitation of such cases compared with the resettlement of neuroses and psychosomatic cases, such as duodenal ulcers, in general industry.

A neurosis is, by virtue of its very nature, an illness which disturbs the patient's relations with others, both at home and at work. If he or she has to go away for treatment as an in-patient, this makes it even more difficult for the patient to develop again the capacity for easy relationships with others which is one of the manifestations of good mental health. On leaving hospital, therefore, the patient needs help in " getting back into circulation ", as it were. The patient needs assistance in recovering his capacity for social relationships at home and at work.

The National Association for Mental Health, during the war, realising this, set up its After-Care Scheme for men and women discharged from the Services on psychiatric grounds. Under this scheme, if the doctor recommended it, and the patient accepted it, a trained psychiatric social worker was made available to help the patient tackle his personal and domestic aspects of getting resettled in civil life—not to solve the problems for him, for only he can solve them, but to put him in touch with the various facilities and agencies that exist and to give him technical advice on using them in tackling the personal and domestic problems of getting going again. We badly need for the civilian psychological patient in peace-time a similar service to help him get resettled in home and work. The development of therapeutic social clubs provides recovering neurotic patients with another excellent opportunity for resocialisation.

Many such patients need, either as part of their treatment, or on return to work, scientifically based vocational advice. The services showed during the war that the outlook for many service psychiatric cases could be greatly improved by specific vocational placement. The Disabled Persons Employment Act has given to the partially recovered patient more chance of employment and more security of employment—what we now need to try to arrange in many cases is more *appropriate* employment. It cannot be done by Act of Parliament. It can only be done by collaboration between the doctors, both family doctors and psychiatrists, the Ministry of Labour and the Industrial Manager—not on a district committee basis but on a case work basis. We need, on a regional or district basis, some unit for handling the vocational problems of psychiatric cases—to advise the patient, not to direct him.

But even if all these things are done we still need one more thing for the successful resettlement of the psychiatric patient in a job. We need industrial units where managements are interested in the health and happiness of the workers, where there is an adequate supply of Industrial Health Service facilities and a good team spirit. Dr. Russell Fraser's survey throws some light on those factors in the industrial scene which are most likely to be associated with a high incidence of psychiatric sickness absence; excessive working hours, boring work, work without initiative or responsibility, work inappropriate to the worker's intelligence All these factors can be modified and, in as far as they are improved, the problem of the resettlement of psychiatric cases is facilitated.

The Regional Hospital Boards and the local authorities are at present laying their plans to discharge their responsibilities under the National Health Service Act. We know, from the decision to appoint Regional Psychiatrists, that the Ministry of Health is well aware of the social importance of psychiatric illness. Therapeutic activities in mental health are largely the responsibility of the Regional Hospital Boards, and preventive activities fall to the local authorities.

Both in terms of human happiness and industrial efficiency the cost of neurosis is very heavy. It will need close collaboration between the two if the resettlement of the neurotic patient in industry is to be successfully achieved. Let us hope that this collaboration will be achieved.

DISCUSSION

Miss E. M. Goldberg (Regional Representative, Region 4, National Association for Mental Health) : I am opening the discussion as a psychiatric social worker who has participated in the After-Care scheme for men and women discharged from the Forces. I should like to take up Dr. Hargreaves' challenge that a similar service is needed in the civilian field. You may know that the National Association for Mental Health is no longer limiting itself to ex-service personnel only, and that the After-Care Service is now available for anyone in need of help. But I would also like to remind you that, to a limited extent, an after-care service for civilian patients, who suffered from nervous or mental disorders, had been carried out by social workers attached to hospitals and psychiatric clinics long before we started this scheme of the National Association for Mental Health, and it has long been the function of the psychiatric social worker to help the patient in his rehabilitation to social life in home and at work.

In view of the present acute shortage of trained workers, which may persist for some time to come, for this work of rehabilitating the emotionally disturbed patient in his environment, it is doubtful whether the clinical and hospital facilities which Dr. Hargreaves indicated will be forthcoming in the immediate future. Also in our present production crisis can we, as a nation, afford an immense expansion of our psychiatric services ? If we are to survive, it would seem that a greater proportion of our population will have to go into productive work, and a very limited number only will be available for psychiatric work, falling far below the ideal estimate. The problem is how to make the best use possible of our limited trained personnel in this field. I would like to suggest that we could do so by encouraging a really effective preventive service which would enable contact to be made with the potential patient as soon as any danger signal is noticed, either at the factory or in the home. This preventive Mental Health team should be as mobile and as accessible as possible to the patient, and its success would depend on collaboration between them and the industrial officers, the social agencies and the Health Services. Such a timely service might prevent a good deal of the long-term breakdown, and it would also act as a sieve, as it were, sorting out the patient's problems from the vocational, domestic and medical angle, thus relieving the pressure on the out-patient clinics, which could then concentrate on treatment of suitable patients and not remain glorified sorting offices as they often have to be at present.

Here the Local Authorities, who under the National Health Service Act have the power to create a preventive Mental Health Service, have a tremendous chance to bring a Psychiatric Community Care Service within the reach of the potential patient in the earliest stages, and so perhaps tend to reduce the complex long-term Rehabilitation Services following prolonged psychiatric illness.

Dr. A. M. Wyllie (Physician Superintendent, Royal Mental Hospital, Aberdeen) referred to the case of patients having had a pre-frontal leucotomy operation, which involved the severance of certain parts of the brain from the main organ, and which must entail some loss of mental efficiency. Employers were therefore somewhat disinclined to re-employ such people, though they were not of the violent type, but were easy to get on with; they were, however, susceptible for a time to epileptic fits. He would like to point out the value of statutory provision in getting these people back into jobs. The statutory provision was a means whereby a Superintendent of a Mental Hospital could get authority to discharge a patient for a year, during which efforts could be made to get him back into his job, and when such a patient engaged in remunerative work it did not constitute any break in his period of incapacity—that is, he would be exempt from National Health Insurance contributions, Trade Union wages need not be paid, etc. If this were known it might be an inducement to employers to take such people into their employ.

Dr. Joshua Bierer (Director, Institute of Social Psychiatry) spoke on the new form of treatment as carried out in Therapeutic Social Clubs. Social rehabilitation was an important part of treatment. In nine years of experience in mental hospitals and out-patient departments in this country, he had been struck by the number of a-social and anti-social people, shy, solitary, lonely people who were either born, or had by certain circumstances become, unable to mix. The experiment of Therapeutic Social Clubs had now been tried for nine years by a small circle of medical men, psychiatric social workers and occupational therapists, and they had come to the conclusion that a-social allergy was a therapeutic social problem, and that the specific treatment against a-sociability was also a complementary treatment in many other forms of nervous or mental illness. It had been found important that the psychiatrists in charge of these Clubs should have one or more trained personnel to assist them and, at a Conference of about three hundred members of the medical profession, psychiatric social workers, etc., which had been held the previous day, it had been decided to start training social therapists for this work, which, it was believed, was one of the cheapest forms of treatment and, while not a panacea, did help, with other forms of treatment, to combat the very widespread social maladjustment of people in this country.

Dr. K. C. Bailey (Medical Superintendent, Tone Vale Hospital, Somerset) said that he would like to stress four things:

(1) the difficulty of diagnosis between neurosis and psychosis and consequently the difficulty that arose when those two tended to be divorced;

(2) the necessity for continuity of treatment. Often neurosis patients started their treatment in a neurosis centre, and were afterwards found to be proceeding to a psychosis, so that they required other treatment, and were moved from the original site and had to start again. He would plead that, whatever line was adopted, the treatment should be continuous, and the personnel, medical and otherwise, should be continuous also;

(3) the lack of co-operation often between the psychiatric clinics and industrial medical officers. This often handicapped very useful work and had to be got over if preventive work was to be satisfactorily carried out;

(4) the desirability of assuring managements and employers that any patient whom they might take on would have the backing of the psychiatric clinic and of the psychiatrist. One could often obtain the sympathy and co-operation of employers if this point were stressed.

Councillor Thomas W. West (Parts of Lindsey Education Committee) asked if Dr. Hargreaves would enlarge upon the subject of the opportunity for prevention of serious nervous and psychological disorders afforded by treatment immediately a person began to flag. This information would be of great value to members of local authorities present, so that they could know what steps might be taken to induce the potential patient to seek treatment at the right stage in order to avoid a breakdown.

On the question of misfits, representatives of local authorities might ask themselves if they had any responsibility in this matter. Parents often wanted their children to do better than other parents' children, and sometimes this was beyond their capabilities. Was it not time that some steps were taken to prevent a well-meaning parent running the risk of causing serious mental injury to the child, by over-straining the child and thus creating a misfit?

It would further be of great assistance if Dr. Hargreaves could give some practical suggestions whereby members of local authorities, and particularly in connection with School Medical Services, might learn how to avoid, as far as possible, the creation of a neurotic. Local authorities were fully aware of the difficulties which faced them, but they wanted to know more about the remedy.

Dr. J. de Ville Mather (West Riding of Yorkshire Mental Deficiency Committee) said that one subject on which he felt very strongly, and on which he hoped Dr. Hargreaves would comment, was the psychopathic personality, which was the burning problem to-day.

As a family doctor, the Medical Officer of an Approved School and the Chairman of a Mental Deficiency Committee, the speaker was continually battling with one of two types—either the inadequates, the wets, or the aggressives. The aggressives were filling the jails and the wets were bleeding the country dry, financially, ecoonmically and industrially. That problem had to be tackled and the remedies were at hand if one only had the courage to use them. The aggressives should be collected into colonies and put on heavy work, as was done in Canada. The wets should be put on to painting or some similar work in which they would be quite happy. If that system were applied throughout the country, much progress would be made.

Dr. G. R. Hargreaves: I agree with Miss Goldberg that the mental hospitals were the pioneers in the use of psychiatric social workers. For many years they have done good work by using them extensively. All I am suggesting is that, if we have not enough psychiatric social workers to tackle all psychiatric cases, rather than devoting most of them to psychotic cases we must devote a large proportion to the re-settlement of the neuroses. I know that that is an unpopular view with those who are responsible for the treatment of the psychoses, but if we really mean what we say about tackling neurosis as a social problem, that is what I believe we must do.

Now, as to Mr. West's question: What can the local authorities do about the problem of neurosis? It would be impossible for me in a short answer to give a summary of the prognosis and treatment of the neuroses. I therefore think I should restrict my answer to a single practical tip. I suggest that in order to answer Mr. West's question one must first consider at what main phases of the individual's development neurosis tends to occur regardless of why, from a technical point of view, it does occur. The practical tip is this: that there are certain characteristic phases of stress at different times in the life of the individual at which he or she is more likely to break down and develop a neurosis than at others. Neurosis tends to show itself as a disorder of social relationships, and any period of life which entails a major change of social relationships on the part of the individual is a period of psychological stress for that individual.

Run briefly through the life of an individual and see for yourself what are these phases: firstly, going to school. This is an obvious major change in the individual's life entailing the development of completely new patterns of social relationship; leaving school—another period of major emotional stress comparable in some ways to being unemployed; going to a first job—developing adaptations to the strange new world of industry; being promoted to a new kind of rôle—for instance, having to stop being a workman, doing things oneself, and becoming responsible for others doing things; changing jobs; and (this is where rehabilitation, which we spoke about earlier, comes in) getting back into one's stride in a job after you have been out of it, regardless of the reason. All these are periods of marked emotional stress for the individual in which he is more likely to develop neurosis than at other times.

Now to try and answer Mr. West's question about what the local authorities can do about it. If they want to help in preventing mental and psychiatric illness they must realise their responsibility towards the individual in each of these phases and see what they can do to diminish the stress. For example, what can the local authority—in its rôle of Education Authority—do to ease the first change (going to school) and the next change (leaving school). At this stage I think we must pass the question back to the local authority and ask them to consider it.

There is one final point about local authorities and what they can do to prevent neurosis which is often forgotten in these discussions on industrial mental health, namely, that all local authorities are employers—some of them very large employers and not all of them very good employers. Another thing they must do, therefore, if they are genuinely interested in the problem of neurosis in industry, is to see that they are handling problems of that type arising among their own employees as well as they can.

RESETTLEMENT INTO WORK

Donald Stewart, M.D., F.R.C.P.

(*Medical Adviser, Austin Motor Company, Babcock and Wilcox Ltd. and James Booth and Company, Birmingham; Member, Industrial Health Research Board*)

The resettlement of people who have suffered or are suffering from nervous or mental disorders, or psychiatric disabilities as we may term them, is a problem the magnitude of which depends primarily on the numbers involved. Nervous disorder, or neurosis, constitutes a group of disabilities covering well over 90% of psychiatric cases, and is found in 20-30% of the sick population of this country. (By sick population I mean the 1½ million cases that are in-patients in our hospitals each year, the other millions of hospital out-patients, those seeking advice from their private medical practitioners, and the countless men and women in a state of impaired well-being on account of which they do not seek medical aid, but who can be identified in any occupational group).

The most recent evidence of the accuracy of this estimate is to be found in an investigation by the Industrial Health Research Board carried out during the late war. The report(1) published last summer shows that, in a group of 3,000 workers employed in the engineering industry, over 25% of all absence through sickness was due to neurosis. Another pointer to the amount of psychiatric illness in the country comes from consideration of the Ministry of Labour's Register of Disabled Persons. On this are the names of 800,000 individuals, 47,000 of which (or 6 per cent.) are recorded as suffering from psychiatric disabilities of a degree accepted as sufficient to reduce their occupational opportunities.

The current figure of unemployment is in the region of a quarter of a million people, of whom about 30% are registered disabled persons. It is fair to assume, considering that psychiatric disabilities vary in intensity, that among this group will be found the disorders most seriously incapacitating from an occupational point of view. I have no precise analysis of these cases, but discussion with Disablement Resettlement Officers of the Ministry of Labour on their problems of placing disabled people leaves no doubt in my mind that there is a hard core of psychiatric cases in each administrative region whose resettlement overtaxes the existing machinery.

The degree to which sufferers from neurotic illness are incapacitated by it is a further aspect of this problem which must be taken into account. The most revealing information available at present comes from a study of the records of men invalided on account of neurosis from the 1914-18 war. Analysis of the psychiatric group on the register at October, 1947, shows that out of the total of 47,000 there were still 5,000 cases from the 1914 war. It is clear, therefore, that one characteristic of neurotic disability, considered as an occupational handicap, is its enduring quality.

Three Groups of Case

We have before us, therefore, from an administrative point of view, a vast and complicated occupational problem which covers the whole range of the worker population, not only those who are unemployed but those who are employed as well. It would be shortsighted, however, to think that in the group of current unemployed we have in front of us the whole national problem of the psychiatrically incapacitated. Other factors operate. For practical purposes, therefore, psychiatric cases might well be put into three broad categories: psychiatric cases among the unemployed; cases recognisably handicapped, i.e., registered as disabled persons because of a psychiatric disorder; and cases less severe, not actively disabled, but discovered, at some time or other, to have psychiatric disability.

The first group is to be found among the unemployed. This includes men and women with psychopathic personalities; some with a basis of mental defect; some who have suffered from psychotic illness; some with an inherent lack of ability to undertake even the simplest task; some with failing mental power associated with advancing old age; and a small group of delinquents some of whom may, from time to time, have been in prison. Such persons often cannot be recommended to employers and have little chance of obtaining or retaining employment in the open market.

The second group, those registered with the Ministry of Labour as psychiatric cases and in employment, have a disability which, from time to time, may render them unfit to work. The very fact that they are on the register, however, means that their handicap is recognized.

A third group consists of those not on any register, and largely already in employment. Many of these cases can be detected in industry by the medical officer who works there. The investigators who produced the report already mentioned for example found, by test and interview, that 10% of the

3,000 so-called normal, fit men and women, showed signs of neurosis. In this group, also, are those who exhibit a psychiatric overlay on organic illness. Anxiety states or depression, for instance—both signs of nervous illness when more fully developed—may well be superimposed on to a prolonged organic disability such as pulmonary tuberculosis or rheumatoid arthritis. The return to work in these and similar cases of frank organic disease is not infrequently retarded by the accompanying neurosis. In this group, too, are to be found men who, through senility and general physical degeneration, are now approaching the end of their effective working life, but who, for economic reasons, must retain some form of employment.

Certain War Results

Further analysis of the psychiatric cases on the Disabled Persons Register shows that 30,000 of them (or 65%) are ex-service men and women from the recent war. Here the problems of re-adaptation to life and work present peculiar difficulties. Many of these were intelligently anticipated, before the end of the war, by the formation of the Army Civil Resettlement Units. This scheme not only made a practical contribution to a national issue but provided important pointers for the future development of the study of occupational health. The importance to the individual of disruption in the continuity of his life experiences by separation from his home, and the effects of a series of totally new experiences, was underlined by the difficulties encountered in resettlement.

This emphasizes what is found in industry that the adjustment of the worker to his job and its circumstances depends as much on continuing ties and loyalties to people and things around him as on his own intrinsic qualities. Realization of the importance of issues of this nature has created a demand for more information about relationships between groups of workers, and between these and the management which controls them. In the field of human relations in industry may therefore be found an important clue to the solution of the subject now under discussion.

Some Methods of Solution

It is true to say that, as a nation, we lead the world in the field of rehabilitation and resettlement of disabled persons. The inter-departmental report on this subject, produced in 1943 and commonly known as the Tomlinson Report,(2) was perhaps the first indication of a national awareness of the size and significance of the problem. Discussing neurosis as a potent cause of disablement, the report showed that opportunities for after-care and follow-up, to enable cases to be retained in suitably selected employment, were sadly lacking, and development of a post-war scheme was quite essential. This report rapidly led to the Disabled Persons (Employment) Act of 1944, with Government recognition both of the problem and the urgent need for action.

Under the new National Health Service Act, treatment of psychiatric casualties in hospitals, clinics and health centres throughout the country is apparently to be put on to more rational grounds. Regional hospital boards, for example, are to have special psychiatric advisers. It may be, therefore, that our new health service will pay attention to the need for more adequate methods of recognition, treatment, and prevention of psychological disorders. But to do this adequately its link with industry must be strengthened, and particularly in this field of resettlement.

Implementation of the Disabled Persons (Employment) Act is carried out by the Ministry of Labour; and what is described as "the post-hospital phase of rehabilitation" is its responsibility. The Minister, under the same Act, established the Disabled Persons Corporation which provides employment for persons so disabled that they are apparently permanently prevented from entering normal industry. To this end what are known as Remploy factories are being opened in different parts of the country. It is the policy of the Corporation, I believe, that men and women working in these factories shall be under observation, so that, if sufficient recovery is attained at any time, they can be guided back into open employment. Cases suffering from psychiatric disabilities will no doubt find their way into these Remploy factories. So this underlines the importance, for these cases, of being under close psychiatric supervision, and the consequent need for the Corporation to provide it.

Similarly, the Grenfell factory scheme(3) in South Wales for unemployed ex-miners permanently incapacitated by pneumoconiosis, will cater for a group, small perhaps, but of considerable social significance, which must inevitably contain many men under intense mental strain. This new scheme will offer new life to some of them.

In the front line of attack of the Ministry's scheme is the Disablement Rehabilitation Officer. Because of the difficulty he has found in obtaining results, two new schemes have recently been instituted to assist him. Medical Interviewing

Committees are to be set up in a number of industrial centres; and members of these committees, consisting of hospital specialists, specialists in occupational health, and other consultants if required, are now being appointed. At these committees personal difficulties will be discussed and action in individual cases determined jointly by laymen and doctors. The fact that time will be spent in consideration of the needs of the individual is itself an important advance in method.

Another new venture is the experimental setting up of non-residential rehabilitation units in certain industrial areas. At these units it is hoped that work will be the main therapeutic agent—productive work if possible. Each will cater for some 120 cases presenting difficulty in rehabilitation and resettlement; and each will develop, it is hoped, on its own individual lines and not to a national pattern. Some will cater largely for psychiatric cases; others will deal with only a proportion of them. This latter group appears to offer, in my view, the better alternative. Success in this venture may well be determined by setting a limit to the size of the psychiatric intake, because, there is no doubt that consideration of such cases, including, as it will, mental re-conditioning, the need to bring about changes in attitude, the demands for vocational guidance, and planned resettlement into work—present problems in time alone (apart from the personnel required to staff the units) which, if not adequately allowed for, may well cause early disappointment and invalidate the experiment.

But, while specific action is being taken by the Ministry to deal on a nation-wide basis with the problem, heed must be given to the fact that there is a considerable volume of other work in this field. Roffey Park Rehabilitation Centre, for example, financed by a number of industrialists, has catered for some years almost wholly for psychiatric industrial casualties. Results in this experiment have been encouraging and have led to the centre now being adapted to deal with demands for education in the varying aspects of this problem. And in industry itself, extensive health and welfare services, in existence often for many years before the recent war, provide a wide fund of knowledge and experience which is available and upon which much of our legislation in this particular field, and its implementation, has undoubtedly been based.

In occupational groups the phenomena of group attitudes, group anxiety, and mass unrest, have been studied in the past largely by the industrial psychologist and the personnel specialist. But a greater opportunity to resolve some of these problems may perhaps be offered through the less remote medical approach. Without the intimacy and warmth of the clinical approach, based on an accurate knowledge of man's normal physical and mental make-up and of deviations from the normal, much of the work of the psychologist, no matter how brilliant and apparently effective, can well be sterile.(4)

Wide opportunity for medicine to take an active part in post-hospital rehabilitation is now offered. The doctor who has insight into and understanding of the psychological reactions of the worker, of his social customs, and of how his present outlook can be determined by fear of unemployment and the feeling of insecurity in his job, can do much to bring about changes in attitude. What industry and those Government departments more intimately concerned with resettlement increasingly require is advice from the doctor closely informed on both industrial and psychiatric matters and who talks the common language.

A further vista in education, both of doctors and laymen, is thus opened out. Training for this specific task now becomes of much significance. But training and education are based on knowledge, and this in turn depends on research and investigation.

A Proposal for Research

Certain proposals for investigation in this field of resettlement are at present under consideration. One of the most important of these is investigation into methods of placement into jobs by studying, on the one hand, the physical and psychological demands of different jobs, and, on the other, the physical and psychological capacities of the individual. In the past this work has been largely concerned with the physical side of the problem.

As doctors or psychologists we know something about assessment of the psychological capacities of the individual—his intelligence, aptitudes, character, stability and behaviour under stress. But the assessment of the psychological demands of different occupations, so that they may eventually be matched with the psychological capacities of the man, opens a further field for research. Here factors such as incentives, effects of different wage systems, fatigue, monotony, boredom, attitudes of supervisors, and the mental effects of the work environment itself, will need careful consideration.

Industry's Potential Contribution to Prevention

Prevention of psychiatric disorders within the occupational field is the concern not only of doctors but all executives employed in it, and in particular those who are responsible for the work of others. High morale in a working group is accompanied by efficiency, good productivity, and a marked disinclination on the part of the individual to develop mental or nervous disorders. And the converse is equally true. Morale in industry is influenced by many factors. Some of these are: development of security, discipline, the phenomenon of leadership, individual behaviour, conditions at the place of work, facilities for joint consultation, the development of joint responsibility, and specific incentives. While the basic incentive to work is that of finance, there are others which can be outlined by pre-supposing the existence of certain qualities: pride in rendering a useful service to the community; satisfaction in doing a job well; contentment and peace of mind, working in security under a competent and trusted leader; fulfilment arising from the performance of creative work; responsibility developing from opportunity for advancement; and a sense of belonging to a community and participating in a common cause.

The application of these incentives would do much to improve relationships and encourage mutual trust between management and employees. Class hatred is engendered by irresponsibility in the spoken and written word, and by the impacts of an over-materialistic conception of human aims. It is based on the inability of the single mind to maintain the balance between spiritual and material values. And it causes, only too frequently, not only a decay of friendliness, but many of those nervous or mental disorders which make re-adaptation to life and work of persons suffering from them one of the foremost human problems of to-day.

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DISCUSSION

Dr. R. F. Tredgold (Boots Lecturer on Industrial Health, Roffey Park Rehabilitation Centre): When I was asked to open this particular discussion I consented with some misgivings as it seemed to me very probable that there would be hardly any new point to add to what had gone before, following such experienced speakers. I think you will probably agree that my misgivings were very well justified and that we have indeed been given a very comprehensive and well-balanced and, above all, very stimulating account of the subject.

There is, however, one aspect I would like to underline. This has already been mentioned by Dr. Bierer, but it seems to me so important that I think it is worth while saying a little more on the subject—that is, the question of social rehabilitation. I think that if more attention were paid to social rehabilitation we could improve those cases who do not somehow seem to benefit as much as we expect in rehabilitation, which is expressed solely in either mental or physical treatment. I feel that the three aspects must go together.

You have already heard a mention of Dr. Russell Fraser's Report, and that, of course, stresses the correlation between neurotic symptoms and the lack of social contact. Which of those is the cause and which the effect, it is very difficult to say. Probably it is wiser to look at the matter as a vicious spiral. But in any case, the neurotic is a bad mixer; he is shy, self-centred, and he forgets his duty towards his neighbour. Not unnaturally he provokes antagonism and that makes him more unhappy than he was originally, which reminds one of the old saw, that a man can have all the self-love in the world and still be miserable.

Now, even if we recognise the need for social rehabilitation, we do not always act upon it, and the point really is that it is no use recognising it without action.

One of the major difficulties of the neurotic, I feel, is his effect on other people. You cannot measure that. You can measure, perhaps, the amount of time and production lost by the neurotic in industry; you cannot measure the amount of time and temper lost by other people through the effect upon them of the neurotic. So, if the neurotic is to improve, he needs more opportunity of social contact, more idea of his own social responsibility, and more stimulation of his own social interests. He must, in fact, be taught to do more for other people.

It is obvious that that can be more easily insisted on in a Club such as Dr. Bierer described, or in a rehabilitation centre, than in private practice, and it is equally obvious how successful some of those centres have been, inside or outside industry. So I believe that short stays in these places are likely to be more productive than frequent conversations in out-patients' departments. Of course, these are not always possible of achievement; but I believe that they are better than the weekly dose of barbitone (even if that is not accompanied by the neglect and hostility which Dr. Hargreaves mentioned).

Miss Goldberg has referred to the part that the psychiatric social worker can play in such cases, but surely it is a much wider matter than one either for the doctor or the social worker. Surely it is a problem for everyone who is interested in the mental health of his fellow creatures—that is everyone here, for a start, and a few more outside. Much can be done if people are alive to the need to develop healthy social interest. In parenthesis, part of the preventive work to be done is to educate the whole community as to what are healthy interests and what are not. But, leaving that aside, the neurotic can certainly thus be helped by all his fellows, not just by the psychiatric social worker, or the general practitioner, or the psychiatrist. That will, incidentally, serve the double purpose of saving the time of the professional, which the professional would welcome, and also, of course, "keeping the professional in his place" which, as you have already heard, is an entirely desirable point of view. More than that, it will go still further in increasing in each individual a sense of his own personal responsibility towards society, and thus may go some way at least towards improving the health of society as a whole.

Dr. F. J. S. Esher (Medical Officer, Sheffield Corporation Mental Welfare Service) said that while he was, in principle, entirely in favour of such a scheme as had been outlined, in practice certain difficulties arose in the rehabilitation of psychiatric cases through the D.R.O.s of the Ministry of Labour. Industry had been asked to employ some 3% of disabled persons, but in many cases works had already made up this number, frequently by having some of the older employees medically examined and so classified, so that there was no room left for the genuine unemployed. This might be overcome by realising that the problem of the disabled unemployed was a problem of the unemployed and not of the employed, and by applying the percentage only to those people seeking employment in a concern, and not to those already working in it.

Another difficulty was that the D.R.O.s and their staffs seemed to have little conception of what the psychiatrist was really seeking to get for his patient. Dr. Esher quoted the case of an ex-Service man, trained as a radio mechanic, and referred to the D.R.O. to apply for the job of radio mechanic in a wireless repair shop or manufacturing concern. He was sent to a retail wireless shop, where the vacancy was for a salesman. The man was extremely nervous, though he could do his job well as a mechanic; he almost fainted, and was promptly turned out, with very bad results to his morale. When such a case was taken up with the Ministry of Labour, the answer would be that they had a doctor on their panel; but the trouble was that that doctor was usually a general practitioner with little or no knowledge of psychiatric cases. Disablement Panels, dealing as they do with so many psychiatric cases, should have on their personnel if not a psychiatrist, at any rate a social worker skilled in psychiatric problems.

Further, even when one had made adequate contact with the D.R.O. (and it was better to send one's own psychiatric worker with the patient to the Council), difficulties might still arise. There was the case of a man who was quite happy at the idea of taking a job as dustman, but when he got to the employing authority the manager assured him that such employment would not be at all suitable, and sent him on with a recommendation to the neighbouring Borough Engineer. The man went, with some despondency, and was offered a job snow-clearing. We had not had much snow since that time, and it was not a hopeful prospect for a man trying to earn his living. So, even when the D.R.O. made an attempt to assist, there was often a certain amount of blocking through lack of understanding on the part of the employers themselves. Better opportunity for the disabled person to discuss his problems in getting a job with the D.R.O. should be made available. There was not, at present, sufficient personal contact, and often the disabled person was only able to talk with the clerk in the Exchange.

It was interesting to note that the estimate of disabled persons included 65% of ex-service personnel, but it was possible that this was due to the fact that ex-service people had come to appreciate the value of well-organised help given to them in military conditions, and were now trying to seek similar assistance in the civil world. That was a big testimony to the efficiency and value to the patient of the psychiatric services in the Forces.

Miss V. R. M. Voller (Psychiatric Social Worker, Miners' Welfare Commission) referred to Dr. Stewart's allusion to the need for co-ordination in resettlement between Industry and the Resettlement Services of the Local Health Authorities. She urged that, in setting up their new services, the Local Authorities should not give more weight to resettlement than to prevention, because it had become increasingly apparent to her in her work how many cases of psychiatric breakdown were brought about by stress in employment which could have been foreseen by far-sighted employers, and thus prevented with the minimum of effort. Many such cases had previously broken down physically, and their physical breakdown had not proved sufficient to bring about the adjustment which was necessary in their work circumstances. There were, for instance, cases of men who had become too old physically for the actual manual stress of their work. Had the managements been sufficiently understanding, and had proper advice been available, adjustments could have been made in conditions so that those men, when physically recovered, would not have found it necessary to break down psychiatrically in order to justify their complete removal from the jobs with which they were unable to cope.

In that sphere of consultation and advice before any signs of psychiatric breakdown had appeared, the local authorities had a wide task to fulfil, and one which was probably a great deal more difficult than the task of resettlement, for few people had at yet any idea of how to set about integrating the preventive medical services with industry. There was no doubt, however, that such integration must be very close and that those working on behalf of mental health must not be content to stay in the clinics but must go right into industry with their understanding of the psychiatric problems and their causes.

Councillor Mrs. R. N. Hales expressed the view that one of the difficulties in preventive work was that the ordinary person had no opportunity of any contact with the experts of the Mental Health Services. People hesitated to get expert advice. The desirability of Community Centres was now generally recognised, and it would seem that a Community Centre might be a very good place from which a Mental Health Service could operate. She would like to see in every Community Centre a kind of Citizens' Advice Bureau, to which people could come for advice and help in their difficulties.

There was also an opportunity at Community Centres for ordinary lay people interested in such matters to help by gathering together in a group and studying psychological matters as far as they could, their function being to try to bring those people who had been suffering from nervous disorders back into the social scene, encouraging them to come to the Community Centre and to take part in activities. There seemed to be a tendency in the modern world for people to be spectators, to sit and watch the experts and not to try to do things for themselves, and this was a practical way in which interested lay people, under the guidance of experts, could help in bringing about a better form of social integration.

THURSDAY, JANUARY 15th

AFTERNOON SESSION

Chairman:

C. P. Hill, Esq.

(*Assistant Secretary, Children's Department, The Home Office*)

The Chairman: I have much regret in announcing to you that Professor Sir Cyril Burt, owing to a University meeting, is unavoidably prevented from presiding to-day. I am commissioned to express his sincere apologies to the meeting. His pioneer work in the study of difficult children is known to you all, and you will all share my regret that he is unable to be present to preside over this discussion.

For my own part, I was much gratified when approached by the organisers of the Conference as head of the Home Office Division which is concerned with difficult children. It gives me an opportunity to express on behalf of the Home Secretary his sense of the value of the work of the National Association for Mental Health, and to give a public welcome to the new partnership of the National Association with the Home Office in two types of voluntary enterprise for the benefit of those acutely difficult children who find their way before the Juvenile Courts. Both of these enterprises have some bearing on the subjects to be discussed this afternoon and are of high importance to the Home Office view. Perhaps I may briefly describe these before I call upon the speakers to read their papers.

Those of you who are concerned with the handling of difficult children under the Education Act of 1944, and those familiar with the Juvenile Courts, will be acquainted with the type of case where a quite young child, often at the beginning of his school career, is brought before the Juvenile

Court by his anxious parents, usually as beyond control, sometimes because he is too young to be charged with an offence. The typical trouble is most often that the boy has begun to stay out late, to swear at and defy his parents, commit senseless damage, sometimes stealing food and money in the home; and the mother is desparately afraid that he will begin to pilfer outside the home and bring serious trouble and disgrace upon his family. Yet, while he is at school, he is, so far, appearing to be perfectly good and normal. He is polite, there is no fault to be found with his behaviour and progress, and there are as yet very few apparent grounds on which a local education authority could properly ascertain him to be maladjusted in the educational sense, that is, so as to require education in a special school for handicapped children.

What is the Juvenile Court to do? Its obvious course is to adjourn the case and to tell the mother to take the child to a Child Guidance Clinic. Sometimes this is successful, but only too often the mother comes back again a little later; the situation at home has not improved and the Child Guidance Clinic recommends that the child shall be treated away from his home surroundings. Many of you are familiar with the sense of hopelessness which is apt to descend upon the proceedings at this stage. The parents will not, as a rule, agree to lose their child for long periods, such as are involved by an Approved School or " fit person " order, and would rather withdraw the proceedings altogether. Some local education authorities would be inclined to stretch a point and ascertain the child as maladjusted, but, as you know, there are, at the moment, few boarding schools for maladjusted children, and this step would not, in fact, do much to remove the child from his home surroundings under present conditions. Even later, when more places are available, it will be found that there are only too many serious cases of fully-developed maladjustment requiring education in such schools, and the pre-maladjusted case, if I may so describe it, of which I have been speaking, cannot expect priority. There does, in fact, appear to be some gap in the statutory provisions for this type of case.

The appearance of these cases at an early stage does, however, give an opportunity to resolve the emotional disturbance before it has become chronic and developed into what one might call a disability—in other words, one has a chance to prevent the development of maladjustment and perhaps delinquency. The importance of this can hardly be over-estimated, and the Home Office, with the assistance of the London Juvenile Court Justices, has secured promises of grants from certain charitable bodies for the provision of an experimental home where cases of the type I have described can come on a voluntary basis for a period of some months for care and treatment away from home, while an attempt can be made by the psychiatric social worker to straighten out the home conditions and correct the parental mistakes to which, too often, the original emotional disturbance is due. I am very happy to say that we have secured the co-operation of the National Association for Mental Health in the running of this pioneer establishment, and we look forward with keen interest to their conduct of this experiment, which, if successful, may lead towards the development of a new social service.

Another exceedingly important service which the Association is undertaking at the request of the Home Office, is the management of two approved schools, one for boys and one for girls requiring long-term psychiatric treatment. In the approved school population, we sometimes come across an adolescent so profoundly maladjusted that he is unable to take part in the life of the approved schools or to benefit by their training. The practical difficulty is often to diagnose such a case at a sufficiently early stage, but this process is being greatly facilitated by the establishment of classifying schools. Once detected, these cases would, it is contemplated, be transferred to a small school where they could be treated on an individual basis by skilled professional staff; and, in welcoming once more the co-operation of the Association in managing these schools, I must emphasise that we must rely very greatly on the Association to define and provide the kind of staff a school of this kind will require.

I do not want to trespass too far on the time or the ground of the other speakers and will conclude by saying, that the importance of training staff is fully recognised by H.M. Government and that provision is made in the Criminal Justice Bill for the training of staffs of institutions for delinquents, including, of course, children. Although it would be improper for me to disclose what will be in the Children's Bill which will be before Parliament in the next few days, it is indeed common knowledge that the Home Secretary has already set up a Central Training Council for the training of staff for homes for deprived children.

METHODS OF HANDLING DIFFICULT CHILDREN IN PRIMARY AND POST-PRIMARY SCHOOLS

(as required under the Education Act 1944)

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In discussing this question it is useful, in the first place, to try to define one's terms and the scope of the topic. This in itself is a very difficult matter, because of the extreme complexity of the problem. In any field where we are concerned with *people*, we come straight away upon the intricacies of personalities and of the factors affecting their adjustment both within themselves and to their environment, so that in order to speak adequately and clearly about the smallest and apparently most simple matter we feel the need to say everything about the whole of the psychology! We have, moreover, constantly to draw lines and to divide people neatly into groups where we know that they won't really divide themselves that way at all. To take one example: we talk cheerfully of " the " maladjusted pupil and propose that he shall, perhaps, be educated in a special residential school for such pupils. But as soon as one begins in sober fact to organise such a school, and to sort out the children on one's waiting list, one realises that unless the most careful selection and gradual infiltration of just those children whom the school at this particular moment can healthily absorb is made, the environment provided by the school may completely fail in its curative intent and one may only have brought into being a little hell-on-earth for both staff and pupils.

One must, however, attempt some degree of definition and delimitation. Let us begin, then, with the meaning to be given to the term " difficult ". The Education Act of 1944 does not use this term but refers to " maladjusted" children, and classes them with the blind, the epileptic, the educationally subnormal, etc., as " handicapped " pupils, for whom special educational treatment is required. This category of pupils had no official counterpart in the 1921 Act, although of course such children obviously existed at that time, and a certain number of them received treatment at Child Guidance Clinics and some were even fortunate enough to gain entry to one of the few boarding or day schools catering for their needs. Official sanction for such provision was made under Section 80 of the 1921 Act, which laid upon Local Education Authorities the duty of " attending to the health and physical condition " of the children in their care and of securing their medical inspection. Under the 1944 Act the concept has changed from that of medical treatment to that of education—surely a very wise shifting of emphasis. The term " special educational treatment " under the New Act covers a very wide range of alternatives: individual or group remedial teaching; boarding out away from home with a suitable foster parent, or in a boarding hostel, coupled with attendance at an ordinary school; attending a day or residential school for maladjusted pupils. In connection with the last form of treatment, it is a great easing of the situation that the Ministry has recently ruled that grant may be re-claimed for children attending at boarding schools other than those officially recognised by the Ministry as schools for the maladjusted, provided the Authority is satisfied as to their suitability and efficiency. Until this advance, to fill up Form 2HP for a child, ascertaining him as a maladjusted pupil needing education in a residential school, was virtually to cut him off from all hope of getting such education, since the few recognised schools had, and still have, very long waiting lists.

What then, is a difficult child? One should perhaps emphasise that 'difficult' here does not only mean " those who are a trouble " to their teachers, parents, or the like, in the sense of being resentful of discipline, impulsive or destructive. I think it is important to emphasise this, because it so often needs emphasis when one is trying to educate teachers in the basic principles of mental health so that they will be sensitive to the main types of maladjustment and recommend the right children for treatment. (This in itself is an important aspect in the handling of such children). If a child is not a nuisance, he or she may sometimes sit for years in school with quite severe but unnoticed neurotic symptoms and may only be detected when some 'crisis' occurs, such as unexpected failure to secure transfer to a grammar school or a sudden breakdown into pilfering, truancy, or incontinence at such a transfer with its necessity of adaptation to just that much more than could be coped with in the familiar environment of the primary school. Phoebe, for example, was referred to the school psychologist by the headmistress of her Secondary Modern School, as being highly intelligent, well-behaved and normal and essentially of the Grammar School type, but having failed to obtain a place in a Grammar School a few months before. Her intelligence quotient on examination proved to be 156, and she did appear, at first contact, cheerful, competent and friendly. An examination of her written English, however, revealed essays that were correct, but inhibited and colourless, conspicuously lacking in the freedom of imagination and vividness of vocabulary one associates with the highly intelligent child. On this evidence she was referred to the Child Guidance Clinic where a long history of family difficulties emerged, beginning with having been born a girl when a boy was wanted and ending with giving an infection to the adored younger brother from which he died, so that the elder sister had endured for years an unexpressed sense of guilt at having been his murderess, which had prevented her from making adequate use of her high intelligence. Cases such as these and such as those mentioned previously, where an apparently well-adjusted child breaks down into open maladjustment at transfer to a new school (a good many of the so-called new maladjustments following on evacuation were also probably of much longer standing) suggest several lines of thought pertinent to the present enquiry.

The most important of these is that the problem of handling these difficult children should not be thought of merely as a matter of the medical or educational treatment of the few (although this is, of course, a very important aspect), but as concerning the whole educational environment in its widest sense. In planning for these children we must not only think of the matter from the angle of providing for the individual difficult child but must include as a very important aim that of improving the whole educational and social milieu. Mention has already been made of the importance of educating teachers in the appreciation of the basic conditions promoting mental health and of the fundamental importance of right emotional education. This may very usefully be done through a comprehensive system of courses of lectures for teachers, under the auspices of a Further Education Department of a local authority, but it is also, in my opinion, assisted by having a Child Guidance Service which is very closely integrated with the school system. I would also suggest that a certain number of the milder forms of maladjustment might well be dealt with in the schools, so that the individual case can be used to educate the teacher and so that the child feels that it is all part of the normal school environment and that he is not 'peculiar'. As, indeed, he is not. For the most part he is an essentially normal person, and whether he becomes difficult or not depends not so much on some specific factor in his make-up as on how much strain his environment demands that he should bear. It may be said that it is better for him in the long run if he does break down, and it certainly seems as if some of his problem behaviour (e.g., stealing such an enormous amount and in such a clumsy way that he is bound to be found out) is his way of saying " Something is desperately wrong with me. Do something about it." But we know that if all these children did their worst we could not possibly cope with them and, that as it is, large numbers of them will have to make a spontaneous recovery or none at all. Moreover, the greater number of them will have to make their recovery, aided or unaided, in the ordinary school and home environment. We cannot hope to take them all out of the normal school and it is perhaps just as well that we should not. The principle behind the Ministry's plans for educationally subnormal children—to remove " lines " between the normal and defective, in so far as any child is educable at all, and to keep the latter in the ordinary school if he can profitably fit into it, may be a useful principle for the difficult child also. He probably is much better left in the ordinary school if he is able to bear it (and to be borne by it), but whether this is possible or not depends on certain factors not directly connected with maladjustment. It depends, for example, on how much else his teachers have to bear. As soon as classes become large and material conditions bad, the " oddity " has to conform. It also depends on how much tolerance there is on the part of his school-fellows. One may say that tolerance is an adult virtue, but, encouraged by their elders, children can be extraordinarily tolerant of each other's oddities.

This suggests a third and perhaps most important factor: the emotional maturity of his teachers, whether they are able to bear the emotional tensions and aggressive feelings thrown out at them by these children and whether they are able to make an exception in exceptional circumstances. It is perhaps impossible for someone who has not been through the mill of running a large school for boys to understand why " discipline " and " justice " are such important concepts for some schoolmasters, so that an exception can never be made because of its subversive effect on " the others ", and once a point of discipline has been brought to a climax it must always be the young who give in. But the facts being in some circumstances as they are, we must, I think, be extremely cautious in, for example, transferring maladjusted children from bad homes to ordinary boarding schools. Whether a form of behaviour is considered outrageous or not depends to a great extent on what are one's standards. Most teachers (especially men, perhaps) cannot tolerate truancy, and a boy who runs away from the boarding hostel of a Grammar School, for instance, may at once be dismissed as a " menace " to the school. On the other hand, in a school or hostel for problem children, running away is an expected reaction and when one asks what line is taken about it, one is merely told, very mildly, that the boys are always found quite quickly and in any case each has his name and address sewn into his clothes and the police know where to look for it. If, however, one picks the right kind of ' ordinary ' school it may be a positive advantage to have a proportion of difficult children among the normal, as is done in some progressive boarding schools, probably to the advantage of both maladjusted and normal.

We must, then, work for psychologically good conditions in all schools, as an important part of our handling of difficult children, but especially, perhaps, at the infant school stage. From this angle the acceptance, by the Ministry, of a larger maximum for the size of classes in Infant Schools, is most unfortunate. Maladjusted pupils are not, of course, commonly manufactured at school, but small classes, and wise handling with the help of an educational psychologist especially interested in this stage of development, can do a great deal to further the readjustment of the difficult child. This is particularly relevant to the problem of the unstable child of relatively poor intellectual endowment. He, as we all know, is one of our major " headaches ", and at present no place for him seems to exist in our educational provision, although probably a good many local education authorities have places for him on paper in their development plans. His instability is very largely a constitutional factor, but, in my opinion, his handicap is greatly increased in severity by the fact that, in the first place, we do not discover him young enough, and in the second, that our infant and junior schools where the classes are large do not easily allow of that personal stabilizing contact between teacher and child, with firm but friendly discipline and control, which he needs if he is to make progress either as a person or as a scholar. When one comes across him in an infant school he has usually been referred as a greatly retarded pupil, unable to learn. Unable to learn he certainly is, but very often it is for emotional rather than intellectual reasons. If we could deal adequately with him at an early stage we could reasonably hope to do something for him in the normal school. When he is not found until later he often has really become ineducable because unteachable, and at the moment we certainly need, as part of our special educational treatment, residential schools specifically adapted to the needs of the unstable dullard. There is room here for a great deal of pioneer experimental work aimed at discovering the best methods of treating such children. The general concensus of opinion seems to be that this type of child does not respond to direct psychological treatment, being unable to develop insight into his condition. He is, moreover, doubly handicapped in that his dull intelligence is accompanied by vacillating attention and weak intellectual curiosity, so that he cannot easily build up the steady interest in a subject or subjects which has such a stabilizing effect on the personality of the normal child, particularly during adolescence. His one hope of salvation seems to be the formation of a warm steady attachment to some stable, mature adult, who will supply him with the sort of motive for growing up which the child in good circumstances finds in his father.

Most people would agree, I think, that children of this type should be in residential schools. There is also general agreement that we need more schools than we have at present for the maladjusted children, not necessarily constitutionally unstable, of higher intelligence; schools where they can temporarily be relieved of the strain of large classes and normal discipline, and where they can, if necessary, have direct psychological treatment. This aspect of special educational treatment, like every other, has its own crop of problems, mainly arising from the fact referred to earlier, that although all these children can be classed as maladjusted they differ so much among themselves that some of them may positively be harmed by association with the others, unless we make a very careful selection of cases. From this point of view it might be better if there were a national rather than a series of local schemes for such schools, so that the more peculiar might be separated from the less: but this, in its turn, would have its own dangers.

The question also arises, at this point, as to whether we have to admit that there are some children so disturbed as to be unfit for any school, in the ordinarv sense of the word. I have known even a school which will cheerfully accept the most extreme cases of maladjustment, ask for the removal of a boy as too disturbed either to respond to treatment or to associate with other children. Most local authorities probably have on their lists a few children of this kind, for whom it is impossible to make any sort of provision, and who yet are in urgent need of control and help. Is a mental hospital the place for them? Ought more of the larger mental hospitals to have a small department, separated entirely from the adult section, where these seriously disturbed children could be under observation, given the treatment they need, and taught, if they are fit for education, and protected from the results of their personal difficulties? In one or two cases this sort of in-patient provision does exist, but there seems a need for an extension of it and an allowance, in some instances, for long-term residence.

Allied to this sort of problem is that of the child with more than one handicap. The Ministry admits such types but illustrates the problem only by reference to the blind child who is physically handicapped or the deaf child who is blind or partially sighted. A far more pressing problem is that of the child with a multiple handicap on the mental side: the epileptic, for example, who is also maladjusted. No school for epileptics can reasonably be expected to keep an epileptic boy if he absconds twenty-two times, pilfers, wishes to chain-smoke and is intolerant of all control. He cannot be sent to an approved school because he is epileptic. So what is to become of him? Cases of this kind, however, are fortunately rare. Most children are essentially normal and seem to have extraordinary powers of resilience, so that by far the greater number of them do respond to the help that is given them or manage to recover without it.

To summarise in conclusion: the essential principles behind the planning of such help should be to refuse to consider the child in isolation from his environment, both human and material, to work for the improvement of that environment at every possible point, and to organize the sort of varied, flexible system of education and treatment in which every kind of difficulty can readily manifest itself and can receive the help it demands.

DISCUSSION

Dr. Alan Maberly (Consulting Psychiatrist, Dr. Barnardo's Homes): It is always a pleasure to me to follow Dr. Bartlett in any discussion, because it is only left to me to underline some of the very admirable points which she raises. She has the characteristic of commonsense, as well as many professional degrees, and that contribution is not so common.

I would agree with her that it is most important not to think of the problem child solely in the sense of nuisance value, and that in general it is a bad local authority as well as a bad teacher who recognises only a few problem children. The question of difficulty is a relative issue, and I think we have got to recognise that any child who is by nature eccentric, different from the average or mean, is, to the extent that he is different, handicapped. It follows from that, then, that a highly intelligent child is, by the fact of being highly intelligent, handicapped as far as its social adjustment is concerned. People are inclined to think in terms of handicap as being only something like low intelligence, rather than high. I would stress that differing from the mean, differing from the normal, at a child's age, is in itself a fundamental problem, and we should not wait until these children break down before taking action.

There was one point on which I would not agree with Dr. Bartlett. She expresses the view that "maladjusted pupils are not commonly manufactured in the schools"; but, of course, they are. They are manufactured for this reason—that going to school is compulsory. If you compel any individual to take any line of action which may not in fact be fitted to his make-up, or personality or equipment, then the person responsible for the compulsion is responsible for any consequences that may be undesirable. That is something which we must never forget or cease to remind the administrators. They like to shirk their responsibility, and that is why they have "no problems".

There are two fields in which this difference from the mean is commonly overlooked. One is in the case of the highly intelligent child whose problems are not always given due weight. But there is another which receives even less recognition, namely, the emotional field. Now the child who is young for its age, or retarded, or, alternatively, precocious for its age is handicapped, and personally I consider that the children I see are more often handicapped in this way—and I see them because of this handicap—than in any other, and it is less commonly recognised. So many of the children sent to us because they are incapable of concentration, unable to attend, restless, and so forth, are quite often merely young for their years, such as the nine-year-old who cannot sit still in class because he is not developed beyond the six or seven year stage.

I would emphasise, as Dr. Bartlett has, that, as far as possible, all these problems should be treated in the ordinary school. We do not want to make the child feel peculiar, very often more peculiar than he already feels. We do not want to single him out, either to himself, or to other people, or to the parents. The parents are already anxious about him, the teacher is already irritated; we do not want to suggest that the child is peculiar in such a way as to be unmanageable in the ordinary school or the ordinary home. In other words, we do not necessarily want to provide more and more special schools, particularly residential schools. We want to help parents and teachers to recognise the difficulty earlier; we want to help them to recognise its nature, and recognise how it can be helped before it has become a question of breakdown. I would strongly support Dr. Bartlett in saying that the most important thing we have to do is to provide teacher and parent education on these lines. The School Psychological Service is working mainly in the schools, and I would say of the Child Guidance Service that its work is mainly with parents, helping parents to be more tolerant and to understand how they can assist in solving this kind of problem.

Next we want to see that where children are chosen to go to special schools, or hospitals, or whatever it may be, they are propertly selected and on rational lines. Selection is very liable to be just on trial and error methods, without any basis of scientific classification. An example of this is the way in which two types of children are often sent to the same school or home, although the required handling is diametrically opposed. One group is the neurotic group, which needs a free atmosphere and a minimum of discipline and pressure; the other is the unstable group which, given such an atmosphere, becomes much worse. The unstable group requires maximum support. The neurotic child, on the other hand, has most often broken down simply because an endeavour has been made to force it into a mould into which it cannot fit. It needs, in other words, freedom, scope for expression, sympathetic handling. No one, however much a genius he or she may be, can handle those two types of children in one place. Nevertheless, this is what is constantly being asked. The approved school contains both. The school for maladjusted children is asked to take both. There seems to be a wide lack of appreciation of this fundamental distinction between two kinds of difficult children. We must not ask special schools to take both. That is the point I particularly want to emphasise—the need for everyone, teachers and parents and administrators, to recognise that first fundamental distinction in order that the special provision that we have shall not fail in its purpose.

Mr. Wm. Hodgkins (Rochdale Education Committee) said that not enough attention was paid to children handicapped in the field of skills. For example, a child who was left-handed suffered emotional maladjustment, and often one found that child referred to a Child Guidance Clinic and, after treatment, returning to school, only to face again the same series of problems and eventually to become a maladjusted child once more. An opportunity was given to-day in the nursery schools to pay attention to such difficulties, and they should be attended to in the pre normal-school life of the child. Difficulties of sight were often mechanically adjusted, but with little attention being paid organically. For children hard of hearing, the tests were not being applied educationally as perhaps they ought to be, and many such children could be assisted. It was probable that teachers were finding more difficulty in these directions than with the emotionally maladjusted child.

Mrs. C. J. Fryd (Association of Parents of Backward Children) stressed the need for guidance to parents of backward children. Those "kind and friendly people" who should be looking after the interests of these children were the parents themselves. In all the writings and discussions on maladjusted and mentally defective children it always seemed to be assumed that the homes were bad, the parents hopeless, and that the children must be taken away and dealt with by other people altogether. Such an idea was not only fallacious but wasteful of expenditure, as well as being grossly unfair to the child and to his parents.

As Founder of the Association of Parents of Backward Chilren, she received countless letters from parents all over the country, from all social classes and of all types of occupation. They did not want their children taken away and put into institutions; they wanted to learn how best they could help them themselves. And though it might be true that the Institutions were not what the public believed them to be, they were bad enough, and in any case there were too few. There never had been sufficient to cope with all the mentally defective and insane people.

Mrs. Fryd urged the establishment of a scheme of parent guidance in order that parents of backward children (and there were over 4,000 of those children last year who were prevented from going to any school at all) were visited and told what to do for their children. Often they were not visited for two or three years at a time and they felt this most keenly. How could they do their best without guidance? Those parents were unable to attend lectures or classes, but would derive great benefit from a correspondence course designed to help them with their problems.

Reference had been made this morning to maladjustment of people in their places of work. How often was that maladjustment caused by the strain of having an unstable child in the family environment?

Mr. James Griffiths (Chairman of Cardiff Health Committee) said that as a "difficult child" of 78 he had his own point of view. After serving for twenty years or so on a Juvenile Bench, he had come to the conclusion that at least 50-60% of the children who came before the Bench were brought there because of lack of parental responsibility, and because of the environment in which they had been brought up. We were bound to get difficult children so long as the housing conditions in this country remained as they were.

In Cardiff about 16,000 people were waiting for houses, and there were two and three families in one house. In such circumstances, it was not surprising if difficult children were produced.

There was another great factor to be considered—the size of the classes in the schools. If there were fifty children in a class, no one could teach them.

What we had to do was to work for the future—a home for every family, not more than 20-25 children in a class, with good, well-trained teachers, and, in a few generations, this country of ours would have the finest citizens of any country in the world.

THE SELECTION AND TRAINING OF STAFFS FOR BOARDING HOMES FOR DIFFICULT CHILDREN

Clare Britton

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It is now generally accepted that some children, while not actually delinquent, are so difficult that it is in the interests of the whole community to provide for their special care and treatment. I should like to remind you that this word "difficult" requires careful definition, but for the purposes of discussion here this afternoon we will take it quite simply to mean those children whose parents cannot manage them satisfactorily at home, and those who are too difficult to be managed in the ordinary residential Children's Home. Obviously, a very wide range of problems will be met with among this group of children, and careful skilled diagnosis will be necessary before children are placed in Boarding Homes or Hostels. But this is a whole subject in itself, and one which we are not discussing this afternoon.

When the Education Act of 1944 made it possible for Local Education Authorities to provide residential care for difficult children, it was hoped at that time that many of the best Evacuation Hostels might thus be kept open and available for adaptation to peace-time uses. Unfortunately, this did not happen to any very great extent, and in spite of a Circular from the Ministry of Education urging this policy, the majority of hostels were closed, and many authorities are now faced with the problem of opening up new work.

But the evacuation experiments had shown the possibilities of the work, and it is clear that the Curtis Committee regard Boarding Homes for difficult children as an integral part of any adequate scheme of community care for children and recognises that preventive, as well as remedial work can be done in this way. So that the need is recognised, and is urgent, but the difficulties in the way of starting up satisfactory work are many, and not the least is the shortage of suitable staff to run the homes, and the lack of facilities for training them. This is the topic for discussion this afternoon, and I should first like to take up the question of *training,* and then go on to the *selection* of staff.

For two reasons I approach this question of training with much hesitation. Firstly, and simply, because obviously we cannot "train" adults to respond to the needs and demands of children, any more than we could train people to be good parents. As David Wills (of the Hawkespur and Barnes Experiments) said at a conference recently, "I cannot say to a member of my staff 'From to-morrow you will be responsible for loving such and such a child.'" Human nature does not work like that, for obviously nobody can love to order, and always the central bit is left untouched by any amount of training. The second reason for my hesitation is because I feel we have not yet enough experience to know the possibilities of the work, let alone the kind of training that is needed for it. Apart from one or two outstanding pieces of private enterprise, such as that of Miss Rendel of the Caldecott Community, the bulk of experience with difficult children was gained during the 7 years of evacuation. But gradually, since the end of the war, a whole new range of problems have presented themselves, and we need another period of time for careful experiment in living and working through these problems with the children before we can see the peace-time possibilities of methods which were satisfactory in war-time. Or, in other words, we *could* say that in common with all war-time industries a period of adaptation from war-time to peace-time production is needed. For this reason I feel that for the present it is better that training should be acquired by actual experience and experiment in the work, rather than by setting up any formal training course which would tend to crystallise and standardise the work at too early a stage. And in fact, we may find that always, training in the residential care and management of difficult children can only be given satisfactorily to people who are in actual contact with the children, for the difficulties have to be felt and lived through in order to be understood.

For those coming into the work, any previous training or experience which gives knowledge of the needs and handling of normal children will be invaluable. Those who have had training in child care, youth work, nursery nursing or teaching, would have a basis of knowledge and experience on which to build. I think it is important for all those taking up work with difficult children that they should have "found their own feet," so to speak, as an adult in relation to groups of normal children. For the management of difficult children can be a frightening experience, and the adult who undertakes it needs to know his or her powers in group management. Therefore, I should like to discuss now the possibilities of training on the job.

Although no training that we can give can create vital relationships between children and staff—the kind of relationships that are necessary if growth is to take place—our training can be designed to encourage relationships that do exist, and we can, by interpreting children's behaviour in the light of their needs, help to build up an understanding *attitude* towards them on the part of the staff. For, given helpful, enlightened attitudes, both children and adults have the chance of gradually finding their way to satisfying relationships. I must say at this point, that I am rather unhappy about this word "train." It savours too much of horses being put through their paces by someone who requires a desired response from them. It does not seem to describe the kind of co-operative effort that I have in mind, in which all concerned with the work try to pool their knowledge and experiences and grow together in their understanding of the children and their ability to help them.

The first question that arises is: Who is to take part in the training, and who is responsible for its instigation? As we are discussing hostels for difficult children, I assume that it is generally accepted that skilled psychiatric help should be available both for diagnosis and placement before the children are admitted, and for advice and general supervision (and possibly treatment) while they are actually in the hostel. The psychiatrist will be ultimately responsible for the work done with the children and will therefore need to maintain close touch with the staff. He will be the person to take responsibility for training them. Help will also be needed from other members of the psychiatric team. The psychologist's advice will be needed on schooling, remedial teaching, and play materials. The psychiatric social worker will probably maintain the closest personal link with the staff, and in such a position will find many opportunities for taking part in training. If the psychiatric social worker has not the time for maintaining the close contact with staff that is necessary if good work is to be done, then I think that someone with similar experience and understanding should be appointed by the local authority to do so, and I suggest that this officer should be the one to see that staff get the help and training they need in the organisation and management of the Home.

If there is no one with whom staff can discuss the day-to-day problems with the children and the work and organisation at the home, then the work will deteriorate, and valuable experience will be wasted and the purpose of the hostel remain unfulfilled. Unless there is someone to understand and safeguard the interests of the hostels, they will quickly become dumping grounds for all kinds of problem cases which are unsuitable for the kind of therapeutic treatment that is possible in a good hostel. Moreover, the staff cannot be expected to shoulder such heavy responsibility alone, and in fact they will not do so, but will tend to shelve responsibility and may resort to second-rate methods, maintaining law and order at the expense of the children. I believe that the staffs of all children's homes need this kind of skilled help and support in just the same way. They absolutely need someone on whom they can rely for understanding and appreciation of themselves and their work. The majority of them have been left without for too long, and their work has suffered in consequence.

I suggest that there are at least three ways in which the training of staff on the job can be undertaken. Some of these I have already indicated, but I should like to discuss them in more detail. The first is the attitude of all concerned in the work towards the staff as individuals. The second is by discussing the children's problems with them, and building up their own confidence in handling them. The third is by more formal teaching methods; the arranging of discussions, lectures, demonstrations, and clinical conferences, by lending books, and encouraging attendance at outside lectures.

In the first place, then, there is the question of attitude towards the staff, and I include here the conditions and administrative arrangements of their work. The best way in which to help staff to show an understanding attitude towards the children, is to show understanding towards them in every possible way. They must feel secure and confident in the work, if they are to give security and confidence to the children. They must have enough confidence in those they are responsible to, to be able to let off steam about the children, or even sometimes to fail entirely with a child. (This work cannot be done well without taking risks and we, as well as they, must be able to stand failure). Administrative details are also of extreme importance to the whole standard of the work. Bills must be paid, repairs done and equipment ordered and delivered as quickly and efficiently as possible. Staff cannot be really understanding about children's lies and tempertantrums when the roof is leaking, or they are short of saucepans. I am convinced that all these matters affect the attitude of the staff to the job—and therefore the quality of the work done with the children. I think that no children should be admitted to a hostel or to any children's home without the staff having been consulted and giving their consent, and really having the right to refuse if they feel that for any reason they must. There are times in the life of any community when a new admission could be managed easily, and times when things are not going so well, and a new child would be most disturbing to staff and children.

When we consider the care with which a family is prepared for the arrival of a new baby (and even then the anxieties and disturbances which are often aroused), it seems preposterous that children should be dumped on staff in homes without any preparation or warning. The setting up of Reception Homes is the only way to solve this problem, but the need is urgent if the quality of the work is to be improved. In the same way I think that staff of homes should be consulted before any child is removed from a home or hostel. If children are removed at a moment's notice, and the staff are not even told why or where they are going, how can we encourage them to build up a real interest and affection for the children. We are asking the impossible, under such conditions. The staff should have a full case history, and details about a child's previous experience are also absolutely necessary if a sound relationship is to be built up between them.

All this seems very obvious. But I am sure that the fulfilling of these conditions is the beginning of building up good work and satisfactory training, particularly if training is to be undertaken. From my own experience, I feel that administrators do not always realise how difficult and important the job is. If they did, they would give priority to its requirements.

Now I should like to take up the next point: that training can be done by discussion with the staff of the children's individual difficulties. Obviously, there is no better way of training, for immediate experience is used as the basis for obtaining further knowledge. Not only is the work objectified for the staff, but tension is relieved and further progress made possible. It seems to me that this objectifying of the work is an important part of any training. For by describing and building up a picture of the work that either is being done now, or is to be done in the future, those responsible for the training are enabling the students to see themselves in relation to it, and to create their own professional attitude or self. The emergence of a professional attitude is important because it denotes the worker's ability to disentangle himself from the problems with which he is dealing, and therefore he is able to use his judgment, knowledge, and skill to give more effective help. It is necessary that the hostel staff should react to each child's difficulties and deprivations deeply and sincerely, but should not become immersed in them, or there is no hope for the children.

Then the third way in which I suggest that training could be carried out is by the arranging of lectures or demonstrations. I think there is real scope here, and I would suggest that staff from all children's homes in an area might combine for short courses of training, arranged, for instance, on one afternoon a week for a period. Subjects of all kinds could be included, and local experts could be called in whenever possible. For example, the child guidance clinic team would obviously be available, and possibly the Medical Officer of Health could be induced to take part, and committee members and others who have special interests. Then, if suitable times could be arranged, local teachers of art, music, cookery, handwork and country dancing, might all be invited to take sessions. Outside speakers and lecturers could be invited to fill any gaps. One of the important aspects of such a plan would be the opportunity for staff to meet each other and discuss their problems together. They would also feel encouraged that trouble had been taken to arrange the course, and good feeling would be created all round. I think it essential that all who lecture to or discuss with staff of homes in this way should have taken the trouble to understand as well as they can the kind of problems and difficulties that have to be faced in the work. Useless suggestions, which would be impossible to carry out, would only make for dissatisfaction and a sense of grievance, so care should be taken in the choice of lecturers. The National Association for Mental Health has often taken part in such training schemes, and I should like to describe two groups I have seen recently at work. The first was a group of 30 matrons of Children's Homes (some dealing with normal, and some with difficult children). All were experienced people, some with 17-20 years in the work. It was a handwork demonstration and they had been induced to try their own hand at rather messy work with paste and paint. At first some were dubious, but gradually the whole group became quite absorbed and they slowly realised the possibilities of the materials presented to them. It was obvious that they had begun to enjoy the work for its own sake, quite forgetting that they were only learning to pass on to the children. The majority were really in touch with their own creative feelings again, and when, at the end of the morning, they were told it was 12.30 and lunch time, there were signs of impatience and annoyance from all over the room. Then there was laughter, for they had suddenly realised that they felt as if they were children again called away from exciting, creative play. There was no need for anyone to point the moral, and I am sure that they had had an extremely valuable training session, for not only had they acquired new skill and methods, but a new sympathy and understanding of the children, by becoming children again themselves for a minute or two.

Another group of men and women (superintendents and matrons of Children's Homes) were being given a lecture by a well-known expert on "Stories and Story-telling". Some of the group thought this was rather a waste of time, and there was slight hostility and a general feeling of restlessness. But gradually, as a story was told to them, they became quiet and were drawn by the story teller's art into a magic circle, and were held there as if they themselves had been a group of children. It was an enriching experience, and when the story was subsequently analysed for them, they were interested and quick to see the possibilities of such methods. Surely the really important point about all training is that those who take part in it must receive something for themselves if they are to have anything to give in their turn to the children. In my opinion, simple sessions of this kind may often be more valuable than any amount of discussion on how to occupy children.

I should now like to turn briefly to the question of the selection of staff for work with difficult children. From the experience we had in Oxfordshire during the war, we came to the conclusion that the most satisfactory arrangement is to have a complete family unit at the centre of each hostel or children's home—a man and wife living with their own children, round which the hostel children can revolve and merge with other members of the staff into the bigger community unit. I feel that there is a sense of stability, of purposeful developing life to the whole group which could not be obtained to the same extent in any other way. It seems to me important that we should recognise that the hostel can never just *be* a home to the children in the ordinary sense of the word. For one thing, the setting is artificial, and a group of difficult children do not in any case possess the ingredients from which a good home is made, however much work is put in on the part of the staff. The idea of a good home has first to be created or revived in them, before they can be ready for one of their own. I believe that the best way of doing this is by letting them see a home existing as the most important and central part of their community life. I think they need the reassurance that loving relationships exist in the world quite apart from themselves, and continue to exist, moreover, in spite of anything that they may do to destroy them. All children fundamentally accept and appreciate the family pattern, and are often worried if staff are not married, or if married couples have no children.

One of the most common objections to the employment of married couples in Homes or Hostels is that seldom are the two people equally good at the work. But surely it is the effectiveness and stability of the total unit that we must try and judge, and not the people as separate individuals. In any group of people comprising a good team, we seldom find them of equal value taken individually. In work of this kind it is the strength of the team that counts, for the hostel children will soon find out any weaknesses in loyalty and affection between the adults.

Unfortunately, I have no experience of the rather more scientific ways of personnel selection, and have always had to rely on the ordinary method of interviews when selecting staff. I do feel that the psychiatrist and psychiatric social worker should have the opportunity of interviewing the candidates separately before the meeting of the Selection Committee. I always used to try and take the prospective staff round the hostel myself. In this way I was able to have a long informal talk and get the candidate's impressions of the hostel and general attitude to the work. I think that a full discussion of previous experience is always important, and I feel happier when the candidate has had a prolonged period at one type of work rather than several changes. If I really could choose, all things being equal, I would always appoint people with wide interests, hobbies and skills. The richer and more developed they are themselves, the more they have to give to the children, and children—especially difficult ones—need and benefit from these things. As to personality, all I can say is that children need stability, warmth and spontaneity from those who care for them.

In conclusion, I should like to suggest that nobody should be expected to do this very exacting work for too long. In my experience there are definite phases in this work. Once staff have brought a group of children through serious difficulties over a period of, say, 5 to 7 years, it seems that they are then unwilling or unable to go back and tolerate serious difficulties all over again. Both staff and children have come through the experience. The group reaches a level of maturity into which a seriously difficult child cannot fit, and any new admissions therefore must be of the less difficult variety. For this reason, I feel that possibly homes for difficult children should be run in groups—to cover a wide area—so that always there is one home at the beginning of the cycle and available for the difficult new cases. Surely this fits in with the experiences of ordinary life, for how many parents having brought up a family could really go back to the beginning and start all over again? I think that very few have the energy to do so.

When the staff have completed a phase of work with a group of children, I think they should then be in a position to go into some other type of social work or into teaching. Would it not be possible for work within a local authority to be inter-changeable, so that suitable teachers, welfare officers and others could do residential work for a period and then return to their original employment if they wanted to. If this were a possibility, I feel that many people would be found to give five years or so to residential work. I think this plan would be worth exploring in relation to the staffing of all Children's Homes. For uprooted children need adults who are themselves firmly rooted in life and not those who, for no fault of their own, have for years been cut off from ordinary social life.

To sum up: I have suggested that training for work with difficult children should at this stage be done on the job by those responsible for the supervision of the work; that staff should have had previous experience and, if possible, specific training for work with normal children, and that, because of the nature of the work, they should not be expected to do it for too long.

DISCUSSION

Miss L. M. Rendel (Hon. Director, The Caldecott Community, Ltd.): I think I have only one point which I should like to add to what Miss Clare Britton has said. I do agree with her that training as you go is probably the safest method of getting the right type of training for your hostels for difficult children, but I would like to urge that this is not carried too far, that you are not attempting to train a whole group of women in a hostel, with psychiatric guidance outside. That guidance no doubt will be most helpful and most sympathetic, but it is the man on the job, on the spot, who has to face the difficulties at the time, and although I think you should have a certain number of inexperienced people who are getting the benefit of the hostel life and the hostel training and getting the benefit of the Child Guidance team that comes in to give lectures, advice, discussions and conferences, you should have on the staff people so much accustomed to groups of children, whether normal or not, that they can conduct their hostel quite irrespective of the immediate guidance of the Clinic at their back. Otherwise you are going to get an attitude of: "Are we doing the right thing? What will they say to-morrow?" and so on. You must have two or three people whose orientation is sufficiently mature, whose knowledge of psychiatric work is sufficiently wide to be able to conduct the hostel for themselves and to give support to the least experienced member in their hostel.

Also amongst the staff there should be people who not only have the knowledge that a hostel has to be treated as a group, but who understand actual group control; because sometimes, if you have group control—I do not mean the old-fashioned type of repression, but true group control—among your staff, they can liberate people who are not able to give very good group control to deal with the individual child. The person with group control is not always the best with the individual child, and your hostel should support the two types; those who can carry the children along as a group, and the others, who would thus be left free, who are better at dealing with the individual child.

The relationship of the psychiatric team to the hostel is one of very great importance. The warden must be in the closest co-operation and closest sympathy, but she should be able to act on her own and detach herself from the general emotional problems that arise amongst the children. She should be able to control her staff, and she should be able to give assurance to members of the staff who are often apt to become very over-wrought and over fatigued—because work amongst a group of maladjusted children of varying sorts is probably the hardest type of work with children which exists.

Mr. G. A. Lyward (Chairman, Home and School Council of Great Britain) said that a former speaker had remarked that we should become less 'psychiatric' and more human. It would seem that the National Association for Mental Health had reached just that point. It was now able to say quite simply, as the last two speakers in effect had said, that what these children wanted was to be really and truly loved, and that in all our discussions we had been exploring in detail the meaning of the words "disinterested love". It was necessary, as Miss Rendel had suggested, to have on the staff of a boarding home, two kinds of people; the amateur, being gradually initiated, and the professional who was already reasonably free of the risk of emotional tangles with the children. There could be no hard and fast rule for training people for this kind of work. But certainly it was only by living amongst the children that one could pass from the emphasis on what they did to a real and deep understanding of what they felt and were. And that was the need.

If the staff were moving easily amongst the children and within itself, in an atmosphere of reasonable freedom, where the motives for action were understood pretty well by all the staff and possibly by some of the older children, then there came into being a new kind of approach to both education and re-education. The problem of mental hygiene was now ceasing to a certain extent to be one of 'health' and was becoming one of 'education', but there was not much point in regarding it as an educational issue if the inspectors dealing with difficult children were going to look at the wrong things instead of trying and knowing how to find out whether there was real love operating in a disinterested way.

We were at the cross roads: we had activity schools for juniors, and nursery schools, but the interest in them was already beginning to wane, and it was going to be hard work if we had to start all over again to persuade people that what the small child really needed was to learn from his environment, to learn by moving about, not by sitting at a desk. We had a good structure in the new Education Act, but the content of our promised education was still open to question.

That was why it was necessary to support the new movement for bringing parents and teachers together in some national way, so that they could explore together what was and what was not true education. The word "education" really meant nourishment.

In the case of the maladjusted children, the two things most overlooked were the amount of time needed, and the amount of money and the way in which it should be spent. We were still in too much of a hurry to put these children half right, to adjust them to society instead of giving them a real chance of becoming adjusted to themselves, which took extra time and, therefore, extra money. And, in regard to expenditure, one was always faced with the fact that local authorities were often prepared to spend money on rows of basins, or w.c.s and so forth, the provision of which sometimes ruled out live domestic issues and left merely academic ones of little value; but they were not prepared to hand over any money for "waste". And the neurotic child often needed money "wasted", if one could use such a term, because he was urgent and grandiose in his ideas, and he often desired things which he would not want to keep for long once he had got them.

Those two points should be considered by administrators, though how they could be met in these days it was difficult to see. There was another point—one must avoid having a strict hierarchy on the staff. One dared not have a staff with strict ideas of relative importance when dealing with difficult children; there must be something more flexible and human. In a home for older children the right atmosphere could fairly easily be brought about by avoiding the issue of credit and discredit. The neurotic lived upon credit, and needed to be gradually freed, so that he was not always seeking credit for what he did and lagging behind in his reserves of energy and strength. Fatigue was one word for the problem of neurosis and when it was studied purely in terms of fatigue one got quite a long way.

The point had already been made that we must not dump all types of maladjusted children together in the same group. On the other hand, it was not entirely true as had been suggested that the same people could not do teaching and healing. We were living in a state of chaos, and education must take account of that, and all schools must be places of healing. If we did not realise that, our schools would fail. Likewise communities for dealing with maladjusted children were places where they could be taught as well as healed if there were good timing and the right atmosphere, neither 'school' nor 'clinic' but a third, a new kind of atmosphere.

The Chairman: One of the most encouraging things to those of us who have been dealing with the acutely difficult children who come before the Juvenile Courts over a period of time, is the very great increase in public interest in the problems which these children represent.

To hear the views expressed to-day on the training of staff and the running of hostels for difficult children is extraordinarily interesting in their bearing on the question that the Home Office has constantly to meet. Some of the views you have heard to-day it would have been almost unthinkable to have expressed at a conference of this kind ten years ago.

I feel that the education of public opinion, and the application of new minds to new problems, and the much wider appreciation of the nature of the problems themselves, are the results of the great upheaval of people, and the evacuation of children in particular, in the last war.

The fact that so many of you have come this afternoon to listen to talks on this subject illustrates the value of the work which the National Association is doing in bringing together people of diverse interests and functions to tackle these problems.

FRIDAY, JANUARY 16th

MORNING SESSION

Chairman:

W. Rees Thomas, K.H.P., M.D., F.R.C.P., D.P.M.

(*Senior Commissioner, Board of Control*)

The Chairman: The subject this morning is one of very great importance. I think most of us have for some months been talking in terms of Regional Boards and of Hospitals belonging to the Ministry, but I think many of us realise that there is another side to health, and particularly to mental health. It may well be—and indeed I think it will be—that this is the most important side of the whole of the Health Services of our country. Local authorities have for long been responsible for Health Services, but now they will be required to concentrate mainly on work in the community, carrying on war against infection in any place where people congregate, in buses, in the cinemas, in the streets, in the schools. For the future welfare of the people, most important duties are laid on local authorities charged with the health of the nation.

I will now call upon Dr. Soddy, who will be dealing in his paper with the experiences of the National Association for Mental Health in carrying out a measure of psychiatric community care.

THE RESPONSIBILITIES OF LOCAL AUTHORITIES IN RELATION TO MENTAL HEALTH AND THE NATIONAL HEALTH SERVICE ACT, 1946

I.—RECENT EXPERIENCES IN PSYCHIATRIC COMMUNITY CARE

Kenneth Soddy, M.D., D.P.M.

(*Medical Director, National Association for Mental Health*)

THE study of mental diseases, disorders and disabilities is now passing out of a purely medical phase into one in which it is fashionable to think in terms of social effects and community influences. One practical result of this has been renewed interest in social work in general and in psychiatric social work in particular, and this modern fashion has left its mark in legislation too, for in Section 28 of the National Health Services Act we read that:

> "A local health authority may with the approval of the Minister, and to such extent as the Minister may direct shall, make arrangements for the purpose of prevention of illness, the cure of persons suffering from illness or mental defectiveness, or the after-care of such persons. . . ."

Since we are now legally bound to plan new provisions for community care among those who present problems of mental ill-health, an account of some of the experiences gained up to now is timely. Public experience of mental health community care schemes, except in certain areas with mental defectives and except for the after-care practised by a few mental hospitals, is to all practical purposes limited to the

Ex-Services After-Care Scheme for Psychiatric Casualties which the National Association for Mental Health (and until lately, the Mental After-Care Association) have been operating for the Ministry of Health under the general guidance of the Board of Control. This scheme represents a major experiment in public provision for a hitherto almost completely neglected section of the community.

Problems Encountered in Mental Health Work

In the pursuit of mental health we are concerned with the attainment of as high a degree of mental efficiency and happiness as possible, and to get a clearer idea of what this may involve it is useful to enumerate the types of problem which may occur through a breakdown in mental health. These are expressed well in a modern American survey as including:

> "all types of insanity; psychoneurosis, anxiety attacks, hypochondria, obsessions and hysteria; psychopathic personality, including sexual perversions and grossly unstable and anti-social persons; persons with lesser degrees of psychotic, neurotic and psychopathic traits; and those whose main trouble lies in relationships with the group, e.g., belligerency, deception, impatience, irritability, quarrelsomeness, unco-operativeness, chronic dependence, inefficiency, laziness, shiftlessness, suggestibility, unreliability, and alcoholism; delinquency, as found in magistrates' courts; minor nervousness; children's behaviour and conduct disorders; school progress problems; epilepsy and mental deficiency."

Almost anyone meeting with this description for the first time will at once find a place in it for himself, but we are concerned here with those whose traits or failings, however commonplace in themselves, are serious enough to cause a handicap in life. As defined by this American survey, our potential patients may easily amount to 10 per cent. of the population, which, incidentally, was the incidence of neurotic illness alone over a period of six months found among a representative sample of industrial workers in the Midlands by Dr. Russell Fraser in his recent investigation for the Medical Research Council. At least a third of the soldiers invalided in the recent war were discharged for primarily psychiatric reasons. We know also that the number of mental defectives in the population is of the order of 10 per thousand of population; that the incidence of lunacy is not far removed from this figure and that only about two-fifths of mental defectives and less than two-thirds of lunatics are at present in receipt of any medical or social treatment.

This American survey found that the number of people actually in serious social trouble in the course of the year of the survey through faulty mental hygiene was about 32 per thousand of population; which means that, if the incidence is similar in Britain—and there is no evidence to the contrary—to do the job properly Bristol would need to provide psychiatric social help for more than 12,000 persons per year and the L.C.C. for over 110,000. And even this degree of help would do little for the minor neurotics and the merely nervous.

The Ex-Services' After-Care Scheme for Psychiatric Casualties

The after-care scheme, first established in 1942, was an attempt to bring psychiatric social help into the homes of discharged war casualties. Psychiatric social workers and their assistants were established in every Civil Defence Region, and to-day 15 P.S.W.s and 37 Assistants with adequate secretarial help (an important factor in efficiency) cover the 11 Regions of England and Wales from 20 offices, though in many areas the service is admittedly most inadequate.

Originally, the social workers visited the patients shortly before discharge from Service hospitals, and again soon after their return home. Thereafter, visits, letters and telephone calls were made as occasion arose and patients were encouraged to call at the office. Later, other ex-Service men and women were admitted to the scheme who had not passed through hospital, and also those whose psychiatric troubles had developed some time after their return to civilian life. In these cases the P.S.W. had to win the full co-operation of the patient—not always the easiest of tasks with misfit and paranoid personalities—and had to get medical advice. In August, 1946, the scheme was thrown open to all comers as it was becoming increasingly more unreasonable to confine it merely to ex-Service people.

Since the start, 13,500 men and women have been accepted and at present our active case load is 4,022. The scheme grew very rapidly; at first it was entirely dependent on naval, military, air force, merchant service and civil defence discharges, but with the shrinking of these sources and without publicity it now continues mainly by virtue of its local reputation. The monthly rate of admission is now about 10 per cent. below the peak period of April-September, 1945, but at the present rate of increase of the civilian entry (from 9 per cent. to 18 per cent. of the total intake in the last six months), an absolute increase in size will occur shortly. It now looks as if 2½ years will be the normal time for patients to remain in touch with the Scheme.

Individual Workers' Case-Load

On the average, each patient is the subject of active work about once per month and at present the number of cases per worker is 105. Experience shows that the best number is 80, possibly more in urban areas and certainly less in scattered rural districts.

Types of Patient and their Disposal

About one-third of our patients come to us suffering from a psychotic illness and nearly one-half have a neurotic type of illness.

Only about one-fifth of the patients come because they, or their families for them, are seeking medical treatment and about one-tenth because of employment difficulties. Most come for a combination of reasons; seeking medical treatment enters as a motive into, say, 50% of our cases, and employment troubles into about 27%; but 20% arrive because of a vague undefined feeling of needing help. This last is one measure of success of the scheme.

Excluding cases sent directly by Service authorities, about 33% are referred by hospitals and doctors, 30% by employment exchanges, 20% by other social agencies and 10% by the patients themselves or by relatives. The fact that nearly as many come from employment exchanges as from all medical sources combined, is an indication both of where mental health problems are recognised nowadays and of the effectiveness of the scheme as a new service on the fringe of orthodox medicine. Moreover, only about a quarter of our patients can name a doctor as being " their own ", so that the scheme is indeed breaking new ground.

Psychiatric social workers work under the advice of a pyschiatrist; they are in touch with all local hospitals and clinics and are most anxious to get treatment for their cases. About 7% of patients at any one time are receiving treatment in mental hospitals, and 2% in neurosis centres. A further 15% are recommended to attend psychiatric outpatients' clinics, but only 7% receive psychological treatment there. These surprisingly low figures may be due in part to the unco-operativeness of the patients and their lack of confidence in psychiatric treatment; but it is also undoubtedly an indication of the unreadiness of psychiatric clinical facilities to take their full burden of work, especially outpatients' treatment. To the scarcity and inaccesibility of clinics must be added the dearth of trained and experienced doctors as causes of this serious state of affairs.

Economic Status

The employment difficulties of our patients are shown most acutely in the 30% who become subjects of discussion between social workers and Disablement Rehabilitation Officers. This figure has been as high as 50% in the past, but the rapid staff changes in the Ministry of Labour and in the National Association for Mental Health make continuity of co-operation difficult. Co-operation, however, is most cordial and close; the social workers attempt to interpret the patient's difficulties to prospective employers and vice versa, and D.R.O.'s on their part find these cases very hard to manage without expert help.

It is surprising to find, however, that some 60% of patients are classed as gainfully employed, and of those in work, 63% found employment by their own efforts and/or aided by a social worker, 7% by reinstatement and only 29% through Labour Exchanges. These figures may help to dispel the false notion that psychiatric cases are helpless and hopeless, and they also indicate the success of our workers in inculcating independence in their patients; 3.3% even found their way into Government Training Centres and mustered some 56 trades between them, which is an extraordinary variety.

The Hard Core of Unplaceables

About 8% of our case-load, in spite of long-continued efforts by social workers who as a profession are the last to admit defeat, remain quite unco-operative in all aspects of resettlement. This, though galling, is only to be expected from psychiatric casualties.

ILLUSTRATIVE CASES

A clearer idea of what this work entails can be derived from a brief description of a few cases taken from the case records supplied by the psychiatric social workers and collated by Miss E. M. Goldberg (Regional Representative, Region II, National Association for Mental Health).

1. *Anxiety Neurosis with a Difficult Reality Situation*

A man of 35, with a good pre-war record, was referred by a neurosis centre two years ago after acute battle experiences. Although married and with two children, he was separated from his wife and, living in a purely mining area, was unable to keep work and was suffering from bouts of violent depression. The social worker found that whatever satisfaction he gained in life came from his allotment, and after discussion with a psychiatrist and a D.R.O. she managed to get a £50 loan from the Red Cross to start a small holding. The Ministry of Pensions helped him to solve other financial problems, and after an initial period of extreme hardship an Agricultural Settlement grant of £100 was obtained, the small holding was extended and a margin of profit appeared. The £50 loan has been repaid, and the patient's general mental condition has improved greatly so that we are hopeful about the permanency of this recovery.

In this case medical treatment could do no more in face of the patient's severe social difficulties, nor were other official and social agencies in the position to see the problem as a whole. The psychiatric social worker, briefed by the psychiatrist, not only interpreted the patient's needs to the other agencies, but she also brought him great relief by letting him talk about his marital and personal troubles. She made it possible for him to follow his main interest by bringing the other agencies to see the complexity of his problems; she supported him through initial financial stress by her understanding and ever available encouragement.

2. *Anxiety and Depression in a Man of Poor Ability*

A merchant seaman of 38, whose wife had gone off with another man, had been discharged by a neurosis centre with a diagnosis of "anxiety state with depressive features". He worked as a casual labourer but became progressively more irritable and depressed. He returned to the neurosis centre, but became so depressed that he was transferred to the local mental hospital as a voluntary patient because of the risk of suicide. He discharged himself, but in the dreary slum environment provided by his aged mother and slovenly sister he became even more depressed and suspicious. The psychiatric social worker persuaded him to return to the mental hospital as a voluntary patient, but this was of little use. He then thought he would like to return to sea and after some discussion this was arranged, the P.S.W. providing him with clothes and literally escorting him to the gangway of the ship. For 18 months he has made regular trips to Europe at first bombarding the worker with requests for help in innumerable difficulties and demanding her immediate attendance on him each time he came home; but lately he has become more independent and has even brought back small gifts for her from abroad.

This man was in three hospitals with no result, but he responded to personal attention embracing his whole environment. He is now thought to be as well as he ever has been. The after-care worker was the only source of support to a lonely soul in a cheerless, affectionless environment.

3. *Recovering Schizophrenia*

A man of 26 was referred by a services' welfare organisation some 3 years after his discharge from the Forces, where he had been a failure. He had subsequently lost innumerable jobs and also defaulted on a Government training course. The psychiatric social worker arranged another psychiatric examination at which the original diagnosis of "psychopathic personality" was amended to "schizophrenia showing signs of recovery". With difficulty he was fitted into a small rehabilitation centre in his home town and during 6 months, employed on toy-making, he recovered sufficiently to take a job as a calendar hand at a laundry, which he enjoys and has held for a year. He is making friends and learning to drive a car and is probably better adjusted now than he has been since boyhood.

The psychiatrist gave wise advice, the rehabilitation centre helped to restore his self respect, but it was the psychiatric social worker who co-ordinated the plan for recovery, who supported the patient personally and to whom he looks even now for approval.

4. *Post-traumatic Disability with Limitation of Function*

A man aged 24 sustained concussion in an air raid and three years later, while still in receipt of a pension, was referred by the Ministry of Pensions. He had a good home and an excellent pre-war record, but in spite of two periods of treatment in a neurosis centre had not managed to put in a full week's work in the last three years. The psychiatric social worker attempted to get him psycho-therapeutic treatment at a clinic, but the latter either could not or would not take him on. She got him two jobs, but he deteriorated and eventually was readmitted to the neurosis centre where he proved querulous and unco-operative. Out again, she got him two more jobs which he found too heavy, and finally installed him in employment on a holiday yacht, which he has kept for several months and which may prove to be permanent.

With the medical profession at the limit of its powers under current conditions, the P.S.W.'s task in this case was to help the patient with personal and employment problems, to help his wife to accept the new order of things and to find a lower occupational level at which he could adjust.

5. *Advice to Early Cases*

A woman called in one day and explained to the psychiatric social worker that, since the latter had been so helpful in the case of one of her neighbours, the National Association might give her some advice about her 24 year old daughter. This girl had always been of a quiet type but had held a good job as a machinist in a clothing factory. Lately, following an unsuccessful love affair, she had become moody and difficult, refusing to go out and had neglected her appearance. She had given up her job, but had with difficulty been persuaded to take an entirely routine job at a lower rate of pay. She flatly refused to have anything to do with hospitals or doctors.

After an unsuccessful attempt to get her to the office, the psychiatric social worker managed to call on her at home. After a hostile beginning, she found relief in talking and slowly revealed schizophrenic and paranoid symptoms. She felt unreal, that she was being persecuted and had many other signs of serious mental illness. At her third visit the psychiatric social worker persauded the girl to go to a psychiatric clinic and then as a voluntary patient to a mental hospital.

In this case, the social worker was the means of securing proper treatment for a seriously ill patient who by reason of her illness would have avoided such treatment unless handled with skill by a trained person. Not only was treatment started early, but the painful and unnecessary drama of certification several months later was avoided.

More could be added about cases in which this type of service is less successful—the unstable adolescent girl and the semi-vagrant psychopathic man and many others; but our main concern is with what can be achieved by social measures. These cases illustrate some of the services to the community which are possible at modest cost in relation to the benefits obtained, and we are in no doubt as to the potential demand.

The Future of Community Care

Community care cuts across established divisions of work. It is not confined only to medical treatment any more than it is confined to social welfare or to the promotion of industrial efficiency. In particular does it stand in danger of dismemberment under the National Health Service Act between Regional Hospital Boards and Local Health Authorities. The arbitrary division made there between medical treatment and social care may have its administrative convenience, but it certainly embarrasses therapists in the mental health field.

The start which has been made, though important, has only affected so far 0.4 in every thousand of the population of England and Wales, whereas this type of service may have a useful contribution to the lives of from 30 to 100 in every thousand. Lest these figures should seem astronomically inflated, the discovery of an incidence of 10% of persons seriously affected by neurosis is recalled to mind. And if to these are added all the psychotics, mental defectives, psychopaths, epileptics and so on who could be helped, the American figures of 32 per thousand annually in need of help, which would mean the provision of one social worker for every 2,500 of population, at least, may not prove a wild exaggeration. Those who are daunted by the expense of such an undertaking would do well to remember the present appalling and incalculable loss to the community from psychiatric illnesses in all their various forms.

The undertaking of mental health community care as a planned activity by skilled workers would not be entirely a new charge on public funds. Much is undertaken already, included in the work of many social and welfare organisations. The same combinations of hereditary and environmental circumstances acting in a family might conceivably drive Father into the arms of the duly authorised officer, Mother to the court missionary, young Alfred to the probation officer, Susie to the moral welfare worker, George to the child guidance clinic, Betty to the N.S.P.C.C. inspector, Fred to the mental deficiency worker and Baby to the health visitor If it should so happen that all these functionaries visited the house at the same moment and coincided with the visit of the rent collector, the rate collector, the gas man, the electricity man, the sanitary inspector, the bailiff and the man from the Prudential, the police would have to be called in to regulate the traffic and to prevent obstruction, and the ratio of officials to local population would certainly exceed the figure of 1 in 2,500.

This illustration is not merely facetious, nor is it a cheap jibe that a family may suffer from a surfeit of social workers; it emphasises the fact that many bodies are interested in mental health problems, but no single one is by training and tradition in a position to see the family's problem as a whole, and most can only act after a disaster has occurred. A well organised psychiatric community care service will do much to relieve other overpressed agencies of problems which they are ill-equipped to solve, and will prevent the occurrence of many difficulties and family tragedies.

Community care cannot be effectively undertaken by Regional Hospital Boards for a number of reasons: most of it falls within Section 28 of the National Health Service Act; little of it can be regarded as medical treatment, in fact, probably less than one-fifth; that part of it covered by the psychiatric social workers of mental hospitals and of out-patients clinics is each about one-tenth. This means that fully three-fifths of the work falls into other spheres. Much of it requires knowledge of local connections for successful prosecution: liaison with employment exchanges, personal knowledge of local employers and labour conditions and day to day co-operation with other social agencies. But the personal understanding of the skilled worker and her local reputation lie at the root of the matter; she must command the spontaneous trust of the community and must not allow herself to be identified too closely with officialdom or with mental hospitals, or get any form of stigma likely to harm her relationship with the public.

Psychiatric social workers are in short supply, but the technique worked out in the after-care scheme, employing assistant social workers in teams under a psychiatric social worker who herself has the backing of a psychiatrist, has proved successful as a means of spreading skill and experience as widely as possible without undermining standards of work.

One of the main concerns at the moment is how to ensure that this work is carried on and expanded satisfactorily in the future. Although the arguments may be in favour of local schemes, it is clear that such an arrangement may suffer from patchiness to such an extent as largely to undo the good work of the schemes, and that standards of work may vary in a bewildering manner from district to district. Also it is impossible for the National Association for Mental Health to negotiate separately with all the Health Authorities in England and Wales—we simply have not the man-hours available to do so; however, we hope that it will be possible for the larger authorities to carry on and expand the Association's pioneer work in community care, and for many of the smaller authorities perhaps to make arrangements with it to carry on on a co-operative basis for groups of areas. The powers for jointly using personnel with the Hospital Regions must also be fully employed.

It will be the business during the second part of this session to discuss in greater detail the principles on which local authority schemes for mental health, including community care, should be worked out.

DISCUSSION

Dr. R. F. Barbour (Medical Director, Bristol Child Guidance Clinic): Dr. Soddy's excellent paper dealt largely with the Ex-Services After-Care Scheme. It so happens that in my work in Bristol I see it from three different angles. Working at the Ministry of Pensions, it is possible to refer to the social workers under the scheme pensioners who come up for routine examination and who are obviously making heavy weather and are in need of some skilled social guidance. Then twice a month I meet the Bristol case-workers and we conference their difficult cases. Thirdly, I have my out-patients' clinic at a General Hospital. To begin with it was one-way traffic. It was nearly always the ex-service cases being sent to the hospital, but during the last year, as you have heard, it was possible to refer civilian cases to the Association who were able to help them direct.

Patients may be referred for a variety of reasons. One person I saw was a lonely man who had come to the Government Training Centre and who felt lost in Bristol. He had never been good at social contacts and they were able to help him to get better contacts and to settle down. A very common case comes up in connection with housing, namely, the person who is unable to represent his case in the best light. It is surprising how many people need help in putting forward their claims for " points " under the housing scheme.

Now this service has certain advantages, from my point of view, over any of the other services which are available. First, let us be quite frank, it is what one might call " untainted." A large number of mental hospitals have changed their names during recent years and there is a reason for this, the reason being that the majority of people, quite unjustifiably, do not like the idea of a mental hospital and even the services which originate from that hospital are suspect. You have heard from Dr. Soddy of the wide variety of referring agencies. Frankly, if these cases were referred to the ordinary mental hospital after-care service I doubt whether there would be nearly so many referrals for the patients just would not come.

A second important advantage is that the interviews take place on neutral ground, that is, not on hospital premises. Another point which seems to make a difference is that the workers do not wear white coats. Why white coats put people off I do not know, but they seem to.

A third advantage, and one which makes nearly as much difference to me as to the patients, is that the workers are mobile. I have in the hospital, where I work, an excellent almoner's service, but they are so hard-worked that it is almost impossible for them to get away from their desks. If there is any field work to be done they have to pass it on to some outside agency, and that means a new person coming in. We have heard a lot at this Conference and will probably hear more of the importance of the personal relationship between the worker and the individual patient. It ought not to be necessary to stress it, but it is.

One of the problems in connection with this service is the question of expense. There is an official scale, as you probably know, for psychiatric social workers and sometimes, if it is a question of having an extra psychiatric social worker, the authorities are a little concerned. But what amazes me is the number of authorities who deliberately and consciously waste the trained workers' time. First of all, there is the question of transport. If a social worker has to go to the homes, she must have transport—and I do not mean a bicycle or the local tram. Secondly, there is the question of adequate secretarial help. Again and again I see the time of first-class people being wasted because the authority will not supply them with efficient secretarial help—which is something more than merely clerical help. It is not an expensive service looked at from the community's point of view, but it could be an even cheaper service if those two points, transport and adequate secretarial help, really got the attention they deserve.

The next point that I want to stress is the tremendous advance in the whole field of psychiatry during the last seven or eight years. Dr. Soddy gave us an extremely impressive list; as far as I can see, it pretty well covered all abnormal emotional reactions, most social maladjustments and most types of faulty behaviour. I could certainly fit myself somewhere into that list! Now psychiatry prior to the war was considered, partly by our medical profession and certainly by a large number of local authorities, as a minor speciality. This is so no longer. But if I had a criticism to make of certain of the official circulars which have been issued by the Ministry of Health it is that these seem to assume that the local authorities realise the importance of the new developments. One finds the words " The Local Authority may and, if the Minister so directs, shall . . . ." and then follow things which we knew about pre-war, but no reference is made to the new developments. We have to remember that in certain parts of the country there is a degree of conservatism; the local authorities will do what is directed but are less certain about these permissive clauses. The permission, I agree, is there but the schemes do not include any definite provision for these developments.

This brings me to the third point that I would like to raise. We have heard a great deal of the " hard core ", the psychopathic tenth, adults suffering from nervous or mental disorders, difficult and maladjusted children, and for these one must not overlook the preventive side. Most psychiatrists, psychologists and psychiatric social workers are agreed that it is in the very early years, probably under five and certainly under seven, when the main distortion of the personality starts. We heard yesterday about " wets and aggressives ". My own opinion is that the " wet " probably starts at about two years of age when he becomes inhibited by an environment that is too forceful for him. In the next paper we shall probably be hearing what the proper provision for young people should be, but there seems to be a real risk at present that we may fall between three stools. The Education Authority is clear as to what happens after the age of five and there are certain permissive clauses in the Education Act of 1944 by which it can make provision for the care of children below the age of five. The local authority is responsible for the care of very young children and infants, while a Regional Hospital Board can provide psychiatric services and run Child Guidance Clinics covering all ages. Now my experience has been that if three separate authorities are empowered to do the same thing, none of them, in fact, act. It is therefore the responsibility of each of us to see that one of these organisations in our own area does, in fact, cover fully this age period, namely under five.

Dr. Soddy has referred to the arbitrary division between medical treatment and social care. In psychological work you cannot, you must not, divorce the individual from his environment, and I feel that there is a danger at present of the needs of administration taking priority over the needs of the individual. Most of us here are administrators and I think it would be an extremely good thing if we had to go through the mill ourselves, that is to see things from the patient's point of view; as administrators we must try to get the opinions a little more frequently of some of the people whom we administrate.

Alderman R. E. Smith (Chairman of Health Committee, Kingston-upon-Hull) enquired as to any steps which the National Association for Mental Health were taking to influence the various Ministries to produce schemes which would make available students in sufficient number at least to carry out interim field-work, which the local authorities would be called upon to undertake. With a greater intake of students it could confidently be expected that the local authorities would do their best to carry out the work which had been so admirably outlined by Dr. Soddy.

Councillor J. M. Larrad (Chairman of the Manchester Health Committee) said that, while he and his Health Committee appreciated the great importance of the responsibilities which had been placed on Local Health Committees under the new Act, their difficulty was to persuade their Council that the Health Committee would be more important under the new Act than it was under the old. There was a general feeling that local authorities were losing control of the hospitals, and, therefore, that the Health Committee would have little to do. When schemes for dealing with all the new aspects of public health were brought forward, there was some difficulty in persuading the Council that these were all necessary. More staff and equipment would be required, for, in building up a new health organisation, it was desirable, if possible, to lose the traditions associated with the old and to start afresh. It was no use running a new Health Service for mental treatment if one used the same staff and the same offices as those familiar to people under the old Poor Law, because there would still be the same prejudice.

There was a long tradition, and a bad one, that mental difficulties were either Acts of God or something the unfortunate person should not have allowed to happen to him. It had taken centuries to overcome this attitude, and if we were to prevent it in future we had to tackle the problem on new lines and build up an organisation which would prevent as well as cure. It was the preventive side which was much the more important. It did not need a trained psychiatrist to realise how a man would deteriorate after one, two, five or ten years' unemployment. Those who had had to deal with Public Assistance in the 'twenties and 'thirties had seen men deteriorate first physically and then mentally. Most of the psychological troubles in this country were due to the fact that we were building an industrial organisation, not to fit human beings, but one into which everybody must fit, and if they did not fit then they were misfits and 'difficulties.' There was hope that the new social security organisation being built in this country now, and which would develop in the next twenty years, aiming at all-round security—of health, of employment, of old age pensions and so on—would go a long way towards preventing many of the mental and psychological difficulties which had beset so many people in the past.

Mrs. M. Ormerod (Chairman, Mental Health Committee of the London County Council) said that while listening to Dr. Soddy she had been able to clear her mind as to what authorities needed in the way of psychiatric social help, and this had caused her to reflect as to the number of workers who would be needed by the larger authorities. She would put in a plea that every area should have a sort of Citizens' Health Advice Bureau, a place nicely furnished, in pleasant surroundings, where those in difficulty could go and would be received by a sympathetic worker who would help them with their problems. From there they could be referred to the psychiatric social worker. It was obvious that within the next few years we could not produce a sufficient number of trained psychiatric social workers to take charge of these Bureaux, and it would be necessary to utilise people who had not had psychiatric training. She would direct the attention of the local authorities, particularly rural ones, to the fact that there was a source of supply from which such workers could be drawn. Social workers and other trained professional women did marry and were often glad, in middle life, to have the opportunity of doing some part-time work of this nature, and would certainly be willing to undertake some training. Local authorities were bound to have difficulty in getting the right type of workers, and this source of supply should be kept in mind. The experience of the After-Care Committee Organisers of the L.C.C. had shown that it often required a whole-time worker, a spare-time worker and a voluntary social worker to deal with the problems of one family alone.

Dr. F. J. S. Esher (Medical Officer, Sheffield Corporation Mental Welfare Service) said that one group of psychiatric patients which had not been mentioned so far, and which, though a small one, was important, was that of the patient who makes an attempt on his own life. In Sheffield it had been made a practice that all cases of attempted suicide should be examined by the psychiatric clinic, and this was a valuable thing to do. People were apt to think that all such people were insane and automatically transferred to a mental hospital, but this was far from the case; many had been driven to their act by insoluble difficulties, or by prolonged domestic strife. It was well worth while to have a psychiatric examination of the patient and also of the other members of his family, who had often contributed to the psychological problem in the home, and he would urge that far greater attention be paid to this in the future by local authorities.

II.—LOCAL HEALTH AUTHORITIES AND A COMPREHENSIVE MENTAL HEALTH SERVICE

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THE inclusion of the Mental Health Services in the National Health Service Act is a most important and valuable step forward. Had they been excluded, there is no question but that the integration of the Mental Health Services into the General Health Services of the country would have been almost impossible at any future date, and it is probable that the Mental Health Services would have deteriorated rather than advanced. At first sight it might appear from the rather scanty attention given to the subject of mental health in the Act that only a very limited service was envisaged. A more careful study of the Act, however, makes it clear that far from this being the case the door is now wide open for the provision of a much more complete and satisfactory Mental Health Service than was ever possible in the past. Much of the work that local authorities carried out under the Lunacy and Mental Treatment Acts and under the Mental Deficiency

Acts has, it is true, been transferred to the Regional Boards, including all the institutional care of these classes of patients, and therefore many local authorities have been prone to take the view that there would be very little for them to do in the field of mental health in the future. Unfortunately, the Circular 100/47 issued by the Ministry of Health to local health authorities, asking them to send in their schemes for a Mental Health Service under the Act, also appears to have been drawn up from a very narrow viewpoint and no doubt partly as a consequence of this many of the schemes sent in by local health authorities were very meagre. Nevertheless, some of the more advanced authorities have been far-sighted enough to realise how far their powers extend, even though their duties are limited, and have shown in their schemes that they are prepared to use these powers in a comprehensive way.

For the benefit of those who are not members of local health authorities, it may be helpful to recapitulate the duties and powers of the latter under the Act.

The statutory Mental Hospital Committee and the Mental Deficiency Acts Committee of the local authorities will cease to exist, and a Health Committee will be set up which will deal with mental health as well as the other health services. It is of some interest that this was one of the most important recommendations of the Feversham Committee Report on the Voluntary Mental Health Services published in 1939. This Health Committee is empowered to set up a Mental Health Sub-Committee to which it can refer all questions dealing with mental health. Both the Health Committee and the Mental Health Sub-Committee can have co-opted members. The Mental Health Services Division of the Ministry of Health take the view that under 6 and 7 of Part 2 of Schedule IV of the National Health Service Act, local health committees can delegate to mental health sub-committees the power of direct co-option. This will enable mental health sub-committees to co-opt persons with a special knowledge of the mental health field, without these having to be first co-opted to the Health Committee. It is suggested by the Minister that local health authorities should appoint a Medical Officer of Mental Health, whole or part-time, who shall be responsible for mental health matters under the Medical Officer of Health, but it is emphasised that the psychiatrist so appointed should be a senior person, and of consultant status.

1. MENTAL TREATMENT

The duties of the Health Authorities in relation to Mental Treatment under the Lunacy Act are to take the initial steps in ascertainment of, and in providing care and treatment for, persons suffering from mental illness. In practice, this will usually mean that steps will have to be taken for the removal of patients who need to be cared for in hospitals or similar institutions. Duly Authorised Officers have to be appointed to take these initial proceedings.

2. MENTAL DEFICIENCY

The duties of Health Authorities in relation to mental deficiency include:

(a) Ascertaining what persons in their area are defectives;

(b) Providing suitable supervision, or taking steps to secure that defectives are placed under institutional care or guardianship, and securing occupation or training for those not in institutions.

3. GENERAL FUNCTIONS

In addition, the Health Authorities have the power and, to the extent the Minister directs, the duty to make arrangements for the prevention of illness and the care and after-care of persons suffering from mental illness or defectiveness. The Ministry has informed the National Association that this is to be interpreted in a far wider sense than the categories coming under the Lunacy, Mental Treatment and Mental Deficiency Acts, and is intended to include uncertifiable psychotics and mental defectives, neurotics, psychopaths and subnormals; in fact, all those people who are seriously handicapped by reason of any mental disease, disorder or disability. A local authority may, with the approval of the Minister, contribute to any voluntary organisation formed for any such purpose.

Department of Mental Health

All these services should normally be carried out through the Mental Health Sub-Committee which, together with its staff, would form a department of Mental Health. This staff would include the Duly Authorised Officers whose function it would be to take the initial proceedings in providing care and treatment for persons suffering from mental illness. In practice, some of these would be drawn from the former Public Assistance officials of the area, who carried out similar functions in respect of indigent patients under the Poor Law. In some cases, psychiatric social workers or mental health workers attached to the staff of the Mental Health Sub-Committee would also be made Duly Authorised Officers. These two types of social worker, as well as health visitors, would be employed in early care work and also in after care in respect of patients discharged from mental hospitals or mental deficiency institutions. By joint user they would no doubt perform similar functions in respect of patients on trial or on leave of absence from mental hospitals, or from mental deficiency institutions. They might also by joint user assist in the work of out-patient clinics at general hospitals or with welfare work in relation to patients in psychiatric hospitals. These social workers would also have important functions in relation to the community care of mental defectives, of unstable children, and of the senile, the sub-normal and the unstable epileptic in association with other departments of the Local Authority.

The Mental Health Department would of course also have its own clerical staff. These should be adequate in number as it is extremely wasteful to utilise the services of highly trained workers for routine clerical work. The co-ordination of records would be a valuable function of such a department.

Administration of Functions in respect of Mental Deficiency

These will include:

(i) The duty of ascertaining what persons in the area are defectives, which will be done by the Medical Officer of Mental Health or by psychiatrists, preferably with a knowledge of mental deficiency, employed by the Mental Health Sub-Committee for the purpose;

(ii) providing suitable supervision for defectives under the Mental Deficiency Acts, which will be carried out by means of social workers and health visitors employed by the Mental Health Sub-Committee;

(iii) taking steps to secure that the defectives are placed under institutional care or guardianship. If they are placed under guardianship, either with their own parents or in a suitable family, their welfare will be supervised by the social workers or health visitors;

(iv) securing training or occupation for those not in institutions. This will involve the employment of special occupation teachers who will work either at a Centre where the defectives attend, or by visiting the defectives in their own homes. Occupation Centres have so many ways in which they help the families of defectives to a fuller and happier life that it is a great pity so many local authorities have not yet realised their responsibility to provide them. These occupation teachers would also be employees of the Mental Health Sub-Committee;

(v) placing defectives who are capable of doing paid work in suitable employment. This also will be the function of the social workers.

Implementation of General Powers

As already stated, in addition to the duties discussed above, local health authorities have the power, to the extent the Minister of Health directs, to make arrangements for the care and after care of persons suffering from mental illness and mental defect and for the prevention of mental illness.

Care and After Care of the Mentally Ill

The scope in this field is obviously very wide. There are many patients who in the early stages of nervous or mental disorder are unwilling to consult a doctor or go to a clinic. Psychiatric social workers should be available for the purpose of visiting such persons in their own homes who are known to be in need of psychiatric treatment; also to answer questions in their own offices and by regular attendance at maternity and child welfare clinics and at other clinics where people may come for general advice, or even in Citizens' Advice Bureaux. In addition, there are a number of persons who need to be away from their own homes while they are receiving out-patient treatment, and for these the Mental Health Sub-Committee could provide hostels, suitably staffed by an experienced and kindly matron—preferably with some knowledge of psychiatric social work—where they could stay in a satisfactory environment.

In respect of after care, it is more and more appreciated that the return to home life and occupation after a period of treatment in a psychiatric or mental hospital is very difficult for the patients, their families, and frequently for their employers also. Unless help and guidance is available, such as can be afforded by trained social workers, there is a great risk that the patient will not make a satisfactory adjustment and will in many cases relapse. When patients are discharged from a hospital or psychiatric unit to an out-patient clinic they will, of course, still remain under the aegis of the Regional Board whose social workers will look after them. In many cases, however, this may not be possible or necessary, but a certain amount of social care will be required to set the patient on his feet again. In many cases a stage will be reached when general friendly contact is all that is needed and which is better given by a social worker of the local authority rather than by a hospital employee. In a certain number of cases, special convalescent homes will be needed as a measure of rehabilitation and these could be provided and staffed by the local health authority. The industrial rehabilitation of the patient is also of the greatest importance, and here again the social worker can play a valuable part in liaison with the managers of employment exchanges and disablement settlement officers.

Voluntary Services and After-Care

For some years to come it is improbable that local health authorities will be able to carry out these extended functions without making use of the services of voluntary bodies, such as the National Association for Mental Health, the Voluntary Associations for Mental Welfare, and the Mental After Care Association, wherever appropriate. It will be remembered that since 1942, at the request of the Board of Control, the National Association for Mental Health undertook the social after care of psychiatric cases in the Forces discharged from mental hospitals. This function they have performed, working in co-operation with the Mental After Care Association, with gratifying success and their services are now being increasingly used for the after care of civilians also. As described in greater detail in the previous paper, up to October, 1947, over 16,000 cases have been dealt with in this way. It is, however, obviously desirable that the local health authorities and the Regional Hospital Boards should ultimately carry out these services themselves; but the major volume of work will probably fall to local health authorities.

Co-operation with Regional Boards

It is obvious that the local health authorities should consult with the Regional Hospital Boards in relation to the provision of care and after care so that there may be neither gaps nor overlapping in the services provided. In many cases the joint user system will be both necessary and desirable, especially if it makes it possible to provide continuity of personal relationships. Nothing disturbs a mentally or emotionally unstable person more than to have to pass through the hands of different people, as this involves the necessity of making fresh adjustments, which they usually find so difficult, and leads to a feeling of insecurity.

Powers in relation to the Care and After Care of Mental Defectives

In every community, there are a number of mentally defective persons who are not subject to be dealt with under the Mental Deficiency Acts or who have been discharged from the operation of the Acts. The Mental Health Sub-Committee should provide supervision and carry out social welfare work for these people by means of their social workers and health visitors.

Preventive Measures

One of the most valuable preventive measures is by health education. In the field of mental health there still exists a most lamentable ignorance on the part of the public and even on the part of the medical profession as a whole. The medieval superstitions and horrific ideas and beliefs surrounding mental illness have persisted to a surprising extent, and to many it is still allied to possession by devils or witchcraft, or regarded as the wages of sin. Mental hospitals, and indeed the very word ‘ mental ’, are associated with fear and anxiety in the patient's mind and even more so in those of his relatives, and there is no doubt that many patients are treated with what amounts to real mental cruelty by their families and neighbours. One of the worst effects of this is that it prevents people from seeking early treatment when they are at the most curable stage of their illness, and it also militates against their recovery because it makes it so difficult for them to return to life in the community when they have been in a mental hospital or home. The extreme cruelty of children towards the less gifted child in school is almost unbelievable, and even teachers are somewhat prone to react with impatience and irritability towards the child who is emotionally handicapped and therefore difficult. It is therefore of the greatest importance that the Mental Health Sub-Committee should undertake a full and active programme of health education, and should also be a centre where people can come for information and where they can receive friendly advice about their problems in this field. There should be regular courses of lectures and discussion groups, with occasional Brains Trusts, some of which should be for special groups, such as parents and teachers, all types of social workers, probation officers, youth leaders and the various women's organisations. The local Health Weeks should include lectures and talks on mental health subjects and a Mental Health Exhibition. It is also desirable that the Mental Health Sub-Committee should have a close liaison with any voluntary association for mental health which exists in the area, and should avail themselves of the opportunities thus created for improving the outlook of the public in relation to the whole subject.

The Senile, the Subnormal, the Unstable, Epileptic and those of Psychopatic Personality

All these different groups represent problems of mental health in the community, widely differing problems, it is true, but all of them capable of being helped to a greater or less degree by the services of trained social workers. If they do not receive this help, they become a serious burden both to the community and to themselves. In relation to the senile, the sub-normal and the unstable, and certain types of psychopath, such as the eccentric vagrant, the National Assistance Bill has certain provisions which could be carried out in association with the social workers of the Mental Health Sub-Committee, and it is hoped that there will be close co-operation between the relevant local authority and the Mental Health Sub-Committee in this field.

The Mental Welfare of Children

There will obviously be much room for co-operation between the Mental Health Sub-Committee and the education authorities in relation to the social care and supervision of school children who are emotionally unstable or maladjusted. In these cases the trail nearly always leads backwards to the home. The social worker and health visitor who are in close touch with the home, and especially the psychiatric social workers, are invaluable in helping to readjust the home to the child. They will also be able to do important work for emotionally unstable or subnormal children who are deprived of normal home life and who will come under the care of the new Children's Committee. There will be much valuable work to be carried out in relation to the welfare of these children.

This brief survey shows how extensive will be the opportunities of the local health authorities in the field of mental health in the future. It is obvious that owing to lack of personnel and the austerities of the times, it will not be possible to carry out all these functions in the immediate future but as a long term policy it is to be hoped that every local authority will make preparations for a truly comprehensive scheme of mental health and will actively work for its fulfilment. When the importance of mental health in the life of a community in terms of happiness, efficiency and morale is fully realised, there surely can be no question that it is a matter of the first priority.

DISCUSSION

Dr. H. Kenneth Cowan (County Medical Officer of Health, Gloucestershire County Council): At this late hour I only want to attempt to underline certain of the points which were made by Dr. Odlum in her very excellent paper. As she has pointed out, there is great scope under the new Act for the development of the Mental Health Services and, if the potentialities are realised, a great deal can be done not only in the treatment of mental disease but in its prevention, and for the welfare of the patient.

To my mind the first and most important consideration is the relationship between the Regional Hospital Board and the local authority. In all our health services there is a very great need for close co-operation between those two bodies, but, if mental health is to have the attention it merits, then there must be the very closest working partnership between them.

Local Health Authorities, as Dr. Odlum has pointed out, have the duty of ascertainment and of prevention and after-care, whilst the Regional Hospital Boards will cater for the patient in hospital. There is, therefore, an artificial administrative division which has no counterpart in the condition from which the patient is suffering. This potential gap must be prevented from becoming an actual one, and the most likely way to prevent it is to institute the system of joint user of officers between the authorities concerned. Doctors, health workers, and others engaged in the mental health service, whether inside the hospital or in the field, must work as a team, bearing in mind always that the patient and his illness must be treated as a whole, and that in no other condition is there a greater need for him to be dealt with by the same team rather than to be passed from one individual to another, with all the readjustment necessitated by his condition of emotional instability.

It is to be hoped, therefore, that when Regional Hospital Boards are making their plans, they will plan beyond the curtilage of the hospitals, and that local authorities will place all their resources at the disposal of Regional Hospital Boards, and will develop them to the extent that the need of the service demands. If this fundamental procedure is followed, it will be possible to build the services on a sure foundation and to develop them in accordance with a regular pattern designed to meet the particular needs of the mental patient.

Dr. Odlum has dealt with the specific duties of the Local Health Authority in ascertainment, both of the patient suffering from mental illness and the mental defective. I do not need to comment on these routine duties, except to say this: that in country areas, particularly, it is essential to ensure that duly authorised officers and others engaged in initial procedure under the Lunacy Acts shall be readily and quickly available to patients, and that their distribution must be decentralised. Moreover, there must be adequate facilities easily available to general practitioners in the way of access to consulting psychiatrists.

It is under Section 28 of the Act, which deals with prevention, care and after-care, that local authorities have their greatest opportunity of building a comprehensive and useful service. The wording of this Section, particularly its reference to mental illness and mental defectiveness, allows the local authority unlimited scope to take any action it may consider decirable for the promotion of sound mental health and the prevention and treatment of mental disease.

First among the steps to be taken, I would place education directed towards placing mental disease in its true perspective in relation to other forms of ill-health. Early ascertainment is just as important as in many forms of physical disease, and the public must be brought to realise that mental illness is just another disease, carrying no stigma, and curable in many forms if treated early. A similar problem had to be faced by local authorities in the early days of the campaign against tuberculosis and it is being dealt with at the present time in relation to cancer.

It would be an advantage in this connection, and also have a stimulating effect on local authorities, if the National Association for Mental Health, possibly in co-operation with the Central Council for Health Education, provided a national background for local education in mental health matters, supplying the material, and, to some extent, the persons on which local authorities could base their local activities.

Dr. Odlum has dealt very adequately with the question of care and after-care. The success which has attended the after-care of psychiatric cases in the Forces, which was so admirably set out in Dr. Soddy's paper, indicates the urgency of the extension of similar facilities to the civil population. Mental Health Sub-Committees of local authorities must at an early date review the needs of their areas in this connection and establish the closest integration of the work with that of the corresponding Regional Hospital Boards.

Adequate machinery must be devised for the reference to the Local Health Authority of patients who require further mental treatment in their own homes after discharge from the mental hospital, in order that the transition from hospital to home, and later to occupation, may be smoothed by encouragement from skilled social workers. There is also an important place in the system for the trained health visitor in dealing with problems related to the general welfare of the family where this has a bearing on the condition of the patient. The existence of a comprehensive organisation outside the hospital will be of the greatest benefit to the patient, and will be an encouragement to hospital medical officers to return to the community many patients who would otherwise have to remain in hospital. Such an organisation will also, as Dr. Odlum has pointed out, be capable of dealing with patients in the early stages of illness, and there is, in addition, a considerable quantity of material available for social investigation into the factors surrounding mental illness. Valuable work can thus be undertaken in the field of research.

Finally, might I emphasise the importance of Local Health Authorities avoiding a narrow interpretation of their functions under this Act at this Conference. You are being persuaded that there is a great field for the development of your mental health services and the fears voiced by a previous speaker about having nothing to do now that the Mental Hospitals have gone, are without foundation. If the sum total of the services to be provided deals merely with new administrative arrangements for ascertainment, and a variation of methods of placing persons in mental hospitals, then to my mind the Act will have failed in one of its most important features. If, on the other hand, the authorities concerned, central, regional and local, realise the vast opportunities which now lie to their hands, it will be possible to make a solid contribution to the total of human happiness by the elimination of unnecessary mental illness and by understanding, friendly encouragement and care of the sufferer and of his relatives.

The Chairman, in referring to Dr. Cowan's remarks concerning the education of the public, said that the National Association has, in fact, a Public Relations Department which deals with this matter, and that the Association would be glad to extend to local authorities any help which they needed.

Councillor Dr. Z. P. Fernandez (Chairman, Leeds City Mental Health Sub-Committee) said that he believed that Leeds was one of the first local authorities to put into operation the working of the National Health Service Act. While waiting for the appointed date, they had already decided that the Mental Health Committee should form a Sub-Committee of the Health Committee. The Mental Health Committee had existed for nearly 34 years, and it was with some despondency that its members found that their work had to be subordinated rather than co-ordinated, though they realised the difficulites.

Social workers could do a great deal, but their work must be co-ordinated by Committees, and instead of having split services the aim must be to unify those services so that the whole benefits would be available.

As the Act gave some power of co-option, possibly a large number of men and women interested in this particular type of work might be co-opted, and it might be possible also to establish Occupational Social Centres. There was also a need for teachers with special training for those centres.

Lastly, there was a great field of work in Child Guidance, and it had been decided in Leeds that the Health Committee should co-operate with the Education Committee. In regard to the training of doctors, an Advisory Psychiatric Committee had already been established before the passing of the Act and was doing good work.

Mr. James Hutchison (Gateshead County Borough Council) asked what was the policy of the National Association for Mental Health in regard to the question of care and after-care in that field. Was it to induce local authorities to accept their full responsibilities, and to make provision for them by the employment of psychiatric social workers, and so on? Or was it to ask local authorities to hand over to the Association the whole of the work in so far as after-care was concerned? Some confusion had been caused by the fact that there already existed the North-Eastern Association for Mental Welfare, which was a voluntary combination of a number of those agencies carrying out welfare work, organised originally by Dame Evelyn Fox of the late Central Association for Mental Welfare, assisted in its finances for the first few years by the Central Association, and eventually taken over by the local authority. A circular had recently been sent out by the National Association to the Health Authorities without any information being given to this particular body. It sought to interest local authorities in the work of the National Association for Mental Health in the same field as that in which work was already being done by the existing local organisation to which reference had been made.

Alderman Frank Duce, J.P. (City of Bradford) said that the City of Bradford had been preparing a mental health scheme for the last two months, and that it was now nearly ready. A difficulty would, however, arise in regard to the costings. If the Minister of Health could have stated definitely that a fairly large grant would be made, local authorities would have been able to prepare their schemes and get their organisation ready for the appointed day; but information as to finance was very vague, and this handicapped local authorities in their efforts. It was also realised that after-care work would necessitate convalescent homes, hostels for the aged, and so on. All these things were costly, and what would it mean? Probably election posters—"Squander mania", "Watch your Rates". Therefore it was the duty of members of this Conference so to create and organise public opinion that it would be possible to put these schemes into operation, and collectively to get over the difficulty in regard to the rate problem. Many people, who did not study what they they were getting in return for their rates, would oppose the schemes put forward, and public opinion must be educated so that every man, woman and child in the country could be cared for from every point of view.

Dr. Eustace Chesser (Society for Sex Education and Guidance) said he had been tremendously impressed with the enormity of the problem with which this Conference was concerned, and equally impressed with the immense amount of time and energy expended in attempting to help those who in one way or another were psychologically unfit. With so much work being done to help the misfits, surely an equivalent amount of work should be done to help the soil which nurtured them? What was required was education in order that parents should know something of the workings of their own bodies and their own minds, their own emotional mechanisms, so that in some small measure they would be able to bring up their children in a manner which would not give rise to the difficulties which we saw around us to-day.

Dr. Kenneth Soddy, in dealing with points raised in the discussion, said:

First of all, in reply to Dr. Chesser, I would say that, because we have not discussed this morning the problem to which he has referred, does not mean that this Association is not fully aware of its importance. The Association is in fact carrying on a large programme of social and educational work designed to meet the needs to which he refers.

In reply to Mr. Hutchison, I would say that it is no part of the duty of this Association to induce local authorities to obey the law—that is to provide services which the National Health Service Act requires them to do. We have no desire to enter into competition with any local authority, but we have been working in various areas, and as far as we are able, in face of our own staff difficulties, we are prepared to stand behind local authorities for the period in which they may find difficulties in starting up the new activities. Our function is to explore these new activities, to establish new schemes, and to hand them over to those whose duty it is to carry them out.

FRIDAY, JANUARY 16th

AFTERNOON SESSION

Chairman:

The Earl of Feversham, D.S.O., D.L., J.P.

(*Chairman, National Association for Mental Health*)

I am particularly pleased to have this opportunity to attend this session where we have under discussion Education for Mental Health both on a national and an international level. I think that we all in this hall will be agreed that the perfectly balanced man and woman requires the trinity of physical well-being, mental poise and spiritual understanding. Without balanced distribution of these components, man's make-up and outlook is incomplete. We have not far to look to bear witness to the fact that modern civilisation is woefully incomplete in mental stability. The news, in whatever form we hear it, is the world-over depressing to a degree that none of us anticipated when World World II was concluded.

In my view Sir Richard Livingstone hits the nail upon the head when he says that this generation has a double task; to create the New Order of which we are always speaking, or, more accurately, to guide the nation through one of the greatest social changes in its history, and also to train human beings fit to live in the New Order. New Orders do not necessarily mean a great civilisation, nor do improved social conditions inevitably make better human beings. Inhabitants of slums moving into a modern housing estate may carry their old habits with them and spoil their new surroundings, and we, too, may be unworthy tenants of a New Order, however new and however good. We have to transform a world with uncertain standards and vague values, with many virtues but with no clear philosophy of life, into one which knows how to refuse evil and choose good, one which is clear in its aims and therefore in its judgment and action.

This will not be done merely by the extension of social services, or the abolition of unemployment, or the hundred and one endeavours of you and of me to improve conditions in these islands alone, but it will be done by a change of mind and a change of heart. That will not come of itself, nor can it be left to chance!

The importance of the subject under discussion this afternoon is, in my estimation, of primary importance, for it should be the aim of all of us who are responsible for mental health in its broadest terms to bring the nation, in its vast ramifications, to realise the greater need for responsibility in parenthood. As Lord Snell said in 1943 in the House of Lords: "Whatever changes we make in education and environment, there will be no lasting cure until there is a deeper sense of parental responsibility towards the children that are born." I believe it is one of our functions, engaged as we are in all aspects of mental health, to see that this most potent, most fundamental factor is brought to a greater extent to the knowledge of the public at large.

I have to report to you our very great regret that Dr. J. R. Rees, who was to speak this afternoon, is unable to do so because he has to attend meetings in Denmark and Sweden in connection with the International Congress on Mental Health of which he is Chairman. We are, however, fortunate in having with us this afternoon Miss Clement Brown who is taking Dr. Rees' place. She has long been known as Tutor of the Mental Health Course of the London School of Economics which she has recently left and has now taken up the duties of Porgramme Secretary of the International Congress.

We have also this afternoon Brigadier Torrie to speak to us as Director of Army Psychiatry, and in that capacity he will need no further introduction to you. I therefore have great pleasure in now asking him to address the Conference.

EDUCATION FOR MENTAL HEALTH AS A NATIONAL RESPONSIBILITY

Brigadier A. Torrie, M.A., M.B., Ch.B., D.P.M.
(*Director of Army Psychiatry*)

The nation is recovering slowly from a psychosis—war psychosis, the major form of mental illness. Like a convalescent patient, it is full of good resolutions concerning the prevention of a recurrence or a relapse. This recurrent disorder has a cycle, a periodicity, and history suggests that we have fewer than twenty years during which we can apply prophylactic measures so that the next attack of our psychosis may not occur or may be aborted. We all have a responsibility to start now informing ourselves of the causes that lead to such war in the mind and gross deviations from national and international health. The subject may be conveniently divided into the need, the resistance and the channels.

First, the need. This need for knowledge requires no stress. As you have frequently heard during this Conference, one in three illnesses is wholly or mainly psychological in origin. The millions of man-hours lost, the untold story of unhappiness, the lowered efficiency and the unharmonious personal, national and international relationships, all point to the urgency of our problem.

Knowledge in itself of the origins of mental ill-health is often an effective preventive. The awareness of the universality of fear diminished the prevalence of the grosser forms of shell-shock in the recent war. Knowledge leads to understanding, and understanding to control.

The need for information concerning the prevention and early treatment of mental ill-health is as great as that concerning the two great scourges of civilisation, tuberculosis and cancer. Campaigns for the spread of understanding of these diseases, and the good results ensuing from early recognition, have been very successful and the same could apply to mental ill-health. At all epochs of life adequate understanding of psychological problems is necessary. From pre-natal days through parturition, infancy, childhood, adolescence, adulthood and old age, problems of emotional adjustment constantly occur. The search for knowledge and the dissemination of information must go on.

In the sphere of industrial relations, much unrest and disharmony could be prevented if the groups concerned were aware of the motives that prompted their precipitate actions. In passing, it is gratifying to note that last month it was announced in the House of Commons that the human factor in industrial productivity was to be studied and the research supported. It is a great advance that the seal of official approval should be given to the psychological approach.

Secondly, the resistance. Everyone, however, does not admit the need for education in mental health. There are those who aver that psychological disorders are other names for selfishness, irresponsibility or original sin. The idea dies hard that lack of courage or willpower is at the root of ill-health that cannot be demonstrated as due to physical causes. Generally it is claimed that a man is fully responsible for his behaviour or else is totally insane. Emphasis is placed on the grosser forms of ill-health, and expensive buildings with oak panelled walls are erected in which the patient can be out of sight and sometimes out of mind. These institutions mostly come into the limelight when some ex-patient writes a best seller and emotional prejudices are aroused. The awakening of the public conscience with regard to other forms of mental ill-health is also necessary, as a nation generally gets the mental health service it demands and deserves.

There is an irreducible number who will always demand that things should be either black or white. The idea of two different shades of grey, or of degrees of responsibility, is anathema to them, makes them anxious and they pour scorn on all psychological nonsense, as they put it.

The first resistance to overcome is the admissibility of discussion of emotional wellbeing or illness. This is frequently taboo and an embarrassment, as not long ago cancer and consumption were. These illnesses were referred to almost with bated breath.

The need for the overcoming of such resistance has been a commonplace in the history of science from the time of Copernicus and Galileo to Darwin and Freud. It must be admitted that the experts in the field of mental health have not always spoken with one voice, but much progress has been made and there is a considerable degree of unanimity nowadays. It is the function of an Association such as this to give expression to this concord and to make it as widely known as possible.

Another factor in the resistance to interest in emotional problems is the tendency to see the mote in the other fellow's eye, but to deny the existence of the beam in our own. Our reluctance to admit periods of emotional stress is due to our expectation that the condition will be ascribed to our own weakness and spinelessness. That, perhaps, is one reason why the recovered or improved patient is not often a propagandist and does little to spread the gospel that treatment often can be effective. The label of emotional illness is looked upon as a tin can tied to the dog's tail.

Thirdly, the channels or means for education in mental health. Mental ill-health is primarily a social disease, and accordingly it is the responsibility of society to concern itself with its prevention and cure. The first social milieu of the patient is the family, and the indoctrination, to use an Americanism, of the parents is an urgent necessity. Physical hygiene is accepted by parents who make some effort at keeping their children in good physical condition as far as nutrition and personal hygiene are concerned. The need for mental nutrition is equally great, and in this connection the simple rules for parents laid down by Susan Isaacs in her book "The Nursery Years" cannot be improved upon. The new Health Service Act mentions the need for prevention of mental ill-health and also the possibility of the use of the health centres for lectures. Classes of instruction for parents should be easily arranged. But before parenthood arrives, during the pregnancy and parturition periods, many emotional difficulties have to be overcome. Much help can be given to the mothers if this time is adequately understood and studied and information conveyed to them by means of their ante-natal clinics.

The greatest hope for the nation is to be found in the adequate handling of its children. The seeds of mental ill-health are sown in the early years. It is during this period that war in the mind begins and conflicts over aggressiveness and difficulties of adaptation to the home and other environments occur. Fuller knowledge of the mechanisms producing these conflicts, and the guilt associated with them, should be available to all who have the care of children, whether in the home or outside it. The knowledge that affection and hostility are felt to the same person should be a commonplace. The home should be the nursery in which the young plant can be protected, and in which the consequent aggression is understood and handled wisely. The subsequent guilt is lessened and the need for finding a scapegoat (which in the long run leads to wars) is diminished. Education for mental health, like charity, begins at home. It is our responsibility to demand that parent guidance clinics should be available throughout the land.

There are many other channels through which information about mental health ought to flow, and I have no doubt that many of you will think of some I have no time to mention. Teachers, industrialists, leaders in all walks of life, from those who govern us to the section foreman and the lance-corporal, ought to be aware of the motives and mechanisms which lie behind normal and unusual behaviour.

There is one group of leaders to whom I shall refer in closing. These are our spiritual leaders. Spiritual well-being can be an antidote to mental ill-health, but, with the late R. D. Gillespie, I believe that physical, mental and spiritual health are interrelated. It is unfortunately true that bad theology can lead to psychological ill-health. There are many psychiatrists who insist that religion is a neurosis and an illusion. I believe that to be true of false theology, but with Suttie I consider that real religion is a psycho-social therapy and a powerful antidote to mental ill-health. In America, some eminent psychiatrists have formed themselves into a group called "The Group for the Advancement of Psychiatry". They have issued a manifesto stating that nothing in their science conflicts with the findings of true religion.

To sum up: The nation is still convalescent. It seeks for a cure in the physical and economic sciences. It ignores the fact that the main causes of unhappiness are social, that faulty personal relationships proceed from lack of knowledge of the emotional life, and that the greatest hope of preventing mental ill-health lies in the development of a campaign for the understanding of the utilisation of such discoveries as are agreed upon by those whose business it is to search for the causes of mental ill-health. Like patriotism, this is not enough. Beyond the attainment of mental health is the achievement of spiritual health, and unless we see this vista we shall be reminded of the words of the Prophet of old, "Where there is no vision, the people perish".

DISCUSSION

Mr. J. H. Wallis (Hon. Secretary, Windsor Mental Health Association): As a layman I am one of the public whom it is intended to educate in mental health. My business in this distinguished throng of experts and professionals is to throw out questions to those who, directly or indirectly, are responsible for carrying out this task.

Brigadier Torrie has spoken of the need to spread an understanding of mental processes. Such understanding, he said, comes from increased knowledge of mental ill-health. He referred also to the resistance which this subject meets from the public. Certainly there is prejudice and even superstition; but there is also some understanding impatience.

Employers, work-people, fathers and mothers, social-workers and teachers and a host of others who are potentially interested have little time for studying mental illness. If you are to educate a confused public, they will first want to know what is meant by mental health. Is it the absence of mental illness, or is it something more? Can they be given positive guidance in achieving good relationships?

We laymen do not want dogma and we do not want scientific explanations. We do want to understand the emotional side of human nature. Can you help us? We do not ask for a System of Success, or Happiness or what not, in Twelve Easy Lessons. We do want to understand the constructive, creative, co-operative abilities of mankind, as well as their opposites. We do not want to be handed out a philosophy of life, but we do want to learn in which direction to look for one.

Brigadier Torrie spoke of the importance of the early years and of family life. That is at least one positive lesson that most parents have learned from mental health teaching, and all honour to those who have got it across. But that is not the beginning. What hope has the child unless the marriage relationship is sound? Everyone deplores the high rate of failure in marriage. Would not a wiser understanding of the emotional needs of children be a stabilising factor in current sexual ethics? Can you not develop the almost universal love-of-children into an understanding of their needs? Can you give us laymen positive guidance, or can you only clear up the mess we sometimes make? How can we learn from children something of their zest for living, their eagerness of response, their humour, their friendliness?

If education for mental health means an honest attempt to answer these questions, it will have a vast and interested audience. How is it to be done?

Brigadier Torrie suggested Parent Guidance Clinics and classes of instruction, but we laymen are a little cautious of being indoctrinated, exhorted and propagandised. If you will treat us as equals, we will come and listen and question and may be sometimes perhaps even tell you something.

Disccussion groups are better, in my opinion, particularly parent-teacher groups to which should be added from time to time psychiatric social workers, educational psychologists and psychiatrists.

Parents and teachers are often warned against saying "don't" too much. May we, with great respect, say the same to you when you are educating us?

Alderman A. W. Bacon (Surrey County Council) expressed his deep appreciation of the amount of knowledge, and the strong desire to do everything possible for people suffering as the result of mental or psychological disorders, which had been manifested at this Conference. In thirty years of service, he had watched the mental hospitals grow from being merely made on behalf of the patients, and it was most encouraging to realise the large number of people taking an interest in matters of mental health. He was sure all members of local authorities present had learned much, and, for his own part, it would be his first desire, as a member of a County Council, to further mental health work.

Dr. Mary Burbury (Manchester Child Guidance Clinic) described some of the difficulties in a small experiment in education in mental health which had been tried out in Manchester.

Early last year the Clinic were asked to organise a course of lectures for parents; this was duly planned and advertised. The population of the area concerned was about three-quarters of a million; five parents attended, and the course was abandoned after three attempts. Discussions were held as to what was wrong, in the course of which it transpired that another County Council had tried a similar experiment with similar results. It was therefore decided to try quite a different line—to start a Social Centre and say nothing about mental health. This time, parents of children at a nursery school and an infant school were invited to a social meeting. The total number of children in the two schools was about 200, and some 20 parents attended, and continued to attend.

Another difficulty then arose, this time with the helpers. They were, from the psychiatric point of view, in far too much of a hurry; they wanted to start immediately giving talks and showing films, whereas the organisers wanted to start by talking, drinking tea and playing games and generally becoming acquainted. The latter line of policy had been pursued, and after about two-and-a-half months the stage had been reached where the parents looked on the workers in the centre as friends, and would discuss things with them, though there were still no specific talks on children or mental health. It would appear, however, that progress was being made to that end, and Dr. Burbury said that, as a result of her experience, she would put in a plea for that more indirect method of approach—trying to lead people somewhere from behind, if one could put it that way, instead of trying to teach them from a platform.

Dr. J. Greenwood Wilson (Medical Officer of Health, City of Cardiff) suggested that Local Health Authorities might make more use of their health visitors in the sphere of mental health. The health visitor was a trained and experienced worker in the field of domiciliary visitation, and already the guide, philosopher and friend of countless families throughout the land. The Conference had heard this morning from Dr. Soddy of the danger of the whole host of specialised workers who beleaguered the home of the unfortunate housewife. That could be avoided by concentrating many of those activities in the hands of the health visitor.

In Cardiff the health visitor, in addition to the duties with which she started, would now advise if there was a case of tuberculosis in the family, or a case of mental deficiency. If she could advise on mental deficiency, why should she not advise on mental ill-health? Why not be a propagandist for mental health, just as she is already a propagandist for physical health? Section 24 of the new Act said that the Health Visitor should advise in the home persons suffering from illness. It did not specify physical illness, and mental illness could be included. Section 28 said that the local authority should arrange for the care and after care of persons suffering from illness; again this could cover mental illness. A system had been established in Cardiff whereby the health visitor went to the hospital before discharge of a patient, saw the physician or surgeon in charge of the case, and then visited the patient's home to make sure that the advice given by the hospital was being carried out. This had been found to be a most valuable service, often preventing relapses, and it was now proposed that one or two of the health visitors who had become expert in this kind of work should train the district health visitors to do the same thing. In a similar way, it would be possible to ask a psychiatric social worker to train the health visitors in all they needed to know for the routine advice in the home on mental ill-health, the psychiatric social worker herself being called in only in case of special difficulty.

The speaker referred to Dr. Soddy's mention of a team of assistant social workers who would help the psychiatric social worker; it seemed to him to be an even better idea to have that help given by the health visitors who were already trained nurses, experienced in home visitation and in dealing with people. This would necessitate employing more health visitors, but of all the items of expenditure undertaken by an authority, none could be more worth while.

Brigadier Torrie: I approve entirely of the method of education by discussion. The Army started the Leaderless Group technique by which a group of not more than eight men and a specialist discuss particular problems. The specialist is one of the group and he does not talk down; if he does so, he at once loses the goodwill and confidence of the men. There is a spontaneous approach to the questions discussed which has proved most successful, and it is certainly not a talking down method.

As regards the definition of mental health: he would be a bold man who would attempt to define it, but I would say that it consists in adequate adaptation to the environment. It must be remembered that the most important thing in our environment is people. I would also add adaptation to our inner environment, because we all have an inner world, most of which we try to avoid.

I agree, too, that parent-education should begin in adolescence, before the boy and girl fall in love. Once they fall in love, of course you can talk forever without getting anything over! I advise teaching what we do know—and we do not know much—about the mental mechanisms that lead to the maintenance of mental health.

With Dr. Burbury's point I agree entirely. I read to-day in the *Lancet* about a discussion on mental health and physical health by University students, and it was suggested that an annual overhaul was the best approach, and that the medical inspection should take place in the centre where the squash racquets, etc., went on, and that the idea of positive health should be in mind all the time. That is the idea we are trying to pursue in the Army, and which is proving most successful.

One point on the problem of health visitors: these people do marvellous work, there is no doubt about that, and are full of well-meaning and goodwill; but psychological problems are very paradoxical, and a certain amount of training is necessary. We do know something, and that knowledge ought to be got over to the health visitor, but knowledge is not enough. Personality counts for a great deal. Some health visitors are excellent at dealing with physical problems, but when they encounter emotional instability they get into deep water. I feel, therefore, that if health visitors are to be used, they should receive adequate training.

EDUCATION FOR MENTAL HEALTH AS AN INTERNATIONAL RESPONSIBILITY

Sibyl Clement Brown, M.A.

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My subject provides me with the best apology for the absence of so distinguished a speaker as Dr. J. R. Rees, whose place I have been asked to take. Dr. Rees is at the moment on his way to Denmark and Sweden to discuss the International Congress on Mental Health.* Their gain is our loss, but surely only here and now, for in the long run national associations, such as our own, grow in strength if they are able to share leaders with other countries. We are justified in feeling some sense of pride to-day in relinquishing our claims on the President of the International Congress.

There are three different aspects of international education in mental health which I should like to discuss.

The first is the need for understanding and agreement between nations in order to safeguard the interests and stability of homeless individuals who leave their native land to become citizens of another country. To move from one society and culture to another is a severe test of stability even when it is the outcome of free choice in favourable circumstances. At the present time, millions of people are being forced to undergo this experience. In the case of children, international standards may lag far behind the child welfare services of any one state.

Secondly, I think we should consider mental health from an international point of view for the sake of our own professional education. It is difficult, if not impossible, to see the institutions of your own society clearly until you have compared them with those of other people. When I return from another English-speaking country, able literally and metaphorically to hear my own accent, then I feel I have learned something.

The third, and by far the most difficult subject about which I want to say something, leads on to our plans for the International Congress. For a quarter of a century there has been an international movement towards what we call "mental hygiene", or "mental health". Have we anything to say which would lead us one step forward in the complex and urgent problems of relationships between people of different nations?

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* International Congress on Mental Health, London, 11-21st August, 1948, organised by the National Association for Mental Health.

Returning now to the first question—the very practical considerations that arise when natives of one country become foreigners in another—there seems to be a definite need for leadership from those who are concerned to safeguard mental health. Many are the formal regulations governing the transfer of nationals, but, as in other spheres, they are more often concerned with restraints than with opportunities. There is need for more understanding of the conditions under which men, women and children can thrive and become good citizens in a new culture, and of more responsibility in using the understanding that we have. The tragedy of thousands of homeless children from the Displaced Persons Camps of Europe, shipped from one country to another like parcels without even a declaration label, may be one of the inevitable consequences of war. It is in some ways more disquieting to find that, even within our own Commonwealth of Nations, it is possible for sometimes bewildered children of eight years old to travel as immigrants to the other end of the world, and for those who receive them to have no record whatever from England of their previous lives or of the conditions under which they were permanently separated from all those who belonged to them. They may be brought up, perhaps in beautiful country, but in almost complete isolation from the community of which they are to become citizens. It is perhaps typical of the time lag between principles and practice that immigrant children in Canada should be supervised by a department called " Mines and Resources ", though this is no reflection upon the sympathetic concern of the staff of that Department, nor upon the standard of child care in a country whose record in this respect is second to none. Some of the Canadian social workers are astonished that we should allow our children to leave Great Britain without more care being taken to provide for continued understanding of their individual needs. Members on the staff of one Home for immigrant children in which I stayed would have been thankful for reports from a Child Guidance Clinic on all the children who came to them.

The value of international exchange for the better shaping of our social services has been recognised for so long that it is surprising to find that there has been no study of its effects. It would make a particularly interesting subject in the history of the services with which the National Association for Mental Health is concerned. Already in the 18th and early 19th centuries, detailed comparisons of the treatment of mental patients in different countries were made by that inveterate traveller, John Howard. The pioneer work undertaken by Tuke and his Quaker friends at the York Retreat aroused interest in many parts of the world. Correspondence in contemporary journals had sometimes a slightly acrimonious flavour. One American writer thought that this new method of "non-restraint" might do for Englishmen, but would never work for "red-blooded Americans". International susceptibilities were again roused by that astonishing woman, Dorothea Lynd Dix, who became a reformer of Scottish hospitals during a rest cure for her health, and was known as the "American invader". The Home Secretary, introducing the Bill which brought about the radical changes she had suggested, told the House that they were important reforms. It was a pity only that they had been "brought about by a foreigner, and that foreigner a woman, and that woman a dissenter!" It was Clifford Beers who stirred men's minds to some realisation of what the experience of mental illness meant to the patient, and the effects of this illumination went right round the world.

The horses of John Howard, the night mail train, on which Miss Dix is said to have raced the nervous Scottish officials to Whitehall with her grim account of the asylums, have been replaced by Constellation aeroplanes and Golden Arrow expresses. But our minds are still slow to span the differences and the common purposes between nations, so that much that we could gain and much that we could offer fails of its purpose. The primitive attitudes of ownership, defensiveness, and jealousy, which we find in children making their first experiments in social relationships, assails many adults as soon as they lose that sense of togetherness which is part of the psychological meaning of nationality. Half-way across the Atlantic, I find myself marshalling the achievements of my own country. Recently I had the privilege and interest of returning from the United States with a group of American teachers coming to work for a year in British schools. It was interesting to notice that, at a friendly meeting in which they were asked questions by a few British passengers, there was always an assumption that these questions would be in the nature of an attack. Struggling to free both sides from this kind of mental fencing, I tried to steer on to a subject which seemed to have no hidden barbs: "We are always told that you have wonderful labour-saving gadgets in your homes, would you tell us about them?" I was met at once with the reply "Oh yes we have, but that doesn't mean that we are any less busy than the British housewife, because our gadgets take so much looking after". In this comparatively trivial illustration lie some of the central problems of international relationships. Few adults are grown up enough to undergo separation from their cultural groups and institutions without anxiety. The need for reassurance of worthiness becomes greater as the individual feels himself more isolated. "Distance makes the heart grow fonder" is, like many other proverbs, less simple than it sounds. If, in our isolation, we are assailed by anxiety, then we may seek for reassurance not only by rallying our defences, but by an over-simplification of our new observations and relationships, by mental stereotypes or even caricatures which reduce individuals to types and experiences to samples with little justification in fact.

International travel, unless it is wisely planned, may then be used to confirm international prejudices, rather than to increase wisdom and tolerance. Yet I know of no other way in which it is possible to gain what might be called social insight. There are signs that in the future, when we have left behind our present deplorable isolation from one another, it may become much more easy to pass from one country to another for education, professional training, and experience through employment. At the present time, Great Britain and many other countries are being honoured by Fellows of the United Nations studying social services. The welcome exchange of teachers has already been referred to. There are schemes for the international interchange of social workers. It is important that we should think out more carefully the conditions under which such exchanges take place, at what age the experience is most rewarding; what kind of person can make the best use of it, and how they can be helped to do so.

This leads me to my third subject. Have we so far learned anything about human beings in our Associations for Mental Health which could lead us to take any step forward in understanding and helping to ease the conflicts between people of different nations?

As you have already heard, we are asking ourselves this question at the International Congress this summer, for which we have chosen the audacious subject "Mental Health and World Citizenship".

There are two contrasting attitudes commonly found towards the attempt to apply the little knowledge that we have to these problems which press so sorely upon us all at the present time. The first is, I think, the most dangerous. It is the risk of over-simplification in our explanations and solutions. This is illustrated in the tendency to explain group relationships, even international attitudes, in terms of the psychopathology of individuals, or, at the other extreme, in terms of certain economic laws. The second is the attitude that such problems are so complex that they will never be susceptible to exact knowledge and that they had, therefore, better be left to the statesmen and politicians whilst we withdraw ourselves into our clinics.

The war surely taught us that to be forced by the pressure of events to make use of such knowledge as we have may lead to valuable discoveries. We have only to think what we learned through the experiences of evacuation and the care of children in hostels. The important thing is not to pretend that our knowledge is more complete than it is. Such intellectual insincerity may be just as much involved in the neglect of wider issues as in too pretentious a use of the little wisdom we have.

There are three special features of this International Congress which make it different from those that have gone before. The first is the wide social significance of the themes. Mental Health is viewed not as something produced by curing individual symptoms, but as a condition of individual and social well-being. The second is the recognition that, in order to become wiser about mental health, we must find means by which the approaches of different sciences and professions may be brought more closely together. We are familiar with this idea in Child Guidance Clinics, but in other fields groups of people equally concerned about people may seldom exchange ideas and may even continue to practice in ways which are mutually defeating. Thirdly, those who organised this Congress had a conviction that such gatherings are not much good unless they work some sort of ferment in men's minds. Such ferment is only likely if individuals are made personally responsible and come together ready to take and to offer the challenge of active feeling and thought.

In order to make the wide social subject a more manageable one, to bring members of different disciplines together and to encourage active responsibility, small "preparatory commissions" or discussion groups have been started in many different countries—countries as widely separated in geography and culture as Holland and the United States, Finland and Brazil, Hungary and New Zealand. Individuals need practice in the sharing of their knowledge and skill in small familiar circles. Their membership of such a group over a period of time may make it less difficult for them to bring the fruits of their discussion to those who have been members of similar commissions, discussing the same subject in other countries. In this way, we may discover together some of the remedies of common problems which lead to conflict and tension, some of the sources of well-being and resilience which it lies within our power to foster. We shall certainly also rediscover our ignorance and that may be a starting point for progress.

At times when we may feel defeated by our apparent failure to behave, so that the phrase " world citizenship " has any meaning, it is a comfort to remember that some lasting achievements in agreements between nations have been made on the level of common concern about human welfare. Occasionally in the face of such needs all national barriers are transcended.

A moving account of an operation carried out at Belsen on a Jewish child was given in a recent book by an Irish and a Dutch author.* The only qualified specialist able to undertake the operation was a German surgeon.

" While I stood there, holding the wound open for him and assisting him, I suddenly realised the extraordinary situation. Here we were in Belsen camp, a first-class German surgeon, an Irish physician, and a Scottish anaesthetist, trying to save the life of a poor little Jewish girl whom the whole state mechanism of that part of the world had been designed to kill. We were pouring out all the skill that each of us had learned down the years. We were working for no possible reward. We were just doctors, brothers in our fight against our eternal enemies—pain, disease and death ".

Is it too much to hope that an honest attempt to share some of our common problems of human well-being may contribute something towards better understanding between the nations?

DISCUSSION

Miss Noel K. Hunnybun (Senior Psychiatric Social Worker, Child Guidance Department, the Tavistock Clinic, London): Miss Clement Brown has said that our minds are still slow to dispel and to tolerate differences between nations. I think that is very true, as do we all. It seemed to me, when reading Miss Clement Brown's paper before this meeting, that one thing I wanted to underline was the importance of our associating here, in this country, with foreign visitors who are coming to us from various countries. I have recently been in Holland and in France, and I have met professional colleagues there and other people who are feeling very sad and depressed because of their sense of isolation. Unfortunately, travel difficulties prevent us from many visits these days, but, in view of the International Congress which takes place in August, it seems to me that we have to think very carefully how each one of us, and our friends who are coming to this Congress can extend interest and hospitality to people from overseas. Sometimes, especially during this difficult period of rationing and domestic problems, we are extremely reluctant to offer hospitality, because we have a sense that we cannot offer very much. I do not think that matters at all. I think we want to have people in our homes in just an ordinary, simple way, letting people take "pot luck", letting them share our experience. What people are hungry for, and what is so wanted at the present time is an opportunity for meeting people on a friendly, personal basis; not just sitting at meetings, or going to banquets, but meeting each other in our own homes.

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* *Journey to Belsen and the Road Home,* by Robert Collis and Han Hogerzeil. (Methuen, 1947).

This reminds me of what Miss Clement Brown said concerning the American teachers in our midst. I think that many of us rather deplore the fact that we do not quite know how to get into touch with them. The National Association is a very busy organisation, but I would like to put yet another job on its already rather over-burdened shoulders. I would like to see an International Bureau established where those of us who are interested in meeting people from abroad, and who are ready to give such hospitality as we can, could get to know of people who are over in this country and have a chance of meeting them. I would like the National Association to think seriously of establishing such a Bureau for professional people interested in mental hygiene or in allied professional work, and I urge that something of this kind should be done.

There is just one other point in Miss Clement Brown's address which I should like to underline. During the war, I had some experience with children who went overseas. I was liaison officer for the British children who went to America through the generosity of our American friends. They went there, as you probably know, in 1940. The work of sending them had to be very hurried and only very scanty particulars were sent with these children. In 1943 I visited America to see these children. I found most excellent arrangements made for them, the most amazing organisation for their supervision and care, but one thing was lacking, and had been lacking all along, and that was knowledge of their backgrounds. I was able to provide quite a lot of information, but that was rather late in the day. What was required was immediate information on the arrival of the children, and beforehand if possible. Difficulties arose in consequence of the absence of knowledge, and many children felt insecurity because there was nobody who knew about their surroundings or the sort of family from which they came. So I would add a plea that we should be careful in these matters, for children have rights and we have duties towards them. If they have to be sent to other countries, the fullest information concerning their background and surroundings should be sent with them.

The Chairman: It falls to me just to say a word or two, in my capacity as Chairman of the National Association for Mental Health, which is the body responsible for this Conference. You will know that this Association, recently founded, incorporates the Central Association for Mental Welfare, the Child Guidance Council, and the National Council for Mental Hygiene. We are a new body, and, in amalgamations covering a subject as wide as mental health, time must necessarily be given for us to shake ourselves down, to get sorted out, and to make full use of the funds of knowledge and experience which these three constituent authorities have built up over so many years. I would ask you to place before us any suggestions or recommendations that you individually, or your local authority, may have as to the manner and the means by which this National Association may best advance and develop in the interest of mental health.

We have, as you will be aware, a vast range of technical and scientific matters to deal with, as well as administrative and political problems, both on the national and local level. We have a variety of opportunity in which further effort can be canalised, not only on the national plane, but also in relation to the international field. Our endeavours will be abortive, unless, under the Regional Hospital Boards and the schemes of local authorities, we of the National Association's Council and Executive can rely upon your full co-operation and support throughout the length and breadth of the country.

We have, as you know, a rapidly advancing organisation of mental health on a regional basis, but it does not cover the whole of the country, and I hope that one of the fruits of a Conference such as this will be the inspiration of local persons in different areas to combine together for the purpose of forming a regional branch of the National Association.

I would like to ask you to consider a viewpoint that I personally hold, namely, that, for the greater extension of the true interpretation of citizenship, we must necessarily have a greater understanding of parent-craft and a more sizeable knowledge of the responsibilities of marriage. Do we not need, for the development of citizenship, facilities for educational courses, such as in Denmark, for the adolescent and also for adult men and women, and facilities particularly for that section of the community which cannot take advantage of higher education, so as to give them at a later age than that at which they are at present continuing their education, a rudimentary knowledge of the great responsibilities of marriage and of parentcraft.

The older I become the more I realise the necessity to be fundamental in our approach to some of the present-day problems, and I would ask you to review whether it is not possible, within a comparatively short time, to establish some system whereby a greater number of the forty-eight millions of this country will have a greater sense of responsibility towards the next generation.

If we in these islands can set an example in something so fundamentally important, then this country will be able to show the way to the international organisation which Dr. Rees, Miss Clement Brown, and many others are engaged in developing. That in itself would have the greatest and most profound effect upon the political and economic structure of the world.

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